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Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Mental Health

REVISED

**COMPREHENSIVE
MENTAL HEALTH
SERVICE
PLAN**

P.L. 99-660

May, 1991

(Including September, 1991 Addendum)

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FOREWORD: A Time of Transition

This Comprehensive Mental Health Service Plan is presented at a time of great change: the Commonwealth has a new governor, William F. Weld, and the Legislature has more new members than has been the case for many years. The times also reflect a period of diminishing resources in contrast to the period of extensive growth between 1986 and 1988 which enabled the Department of Mental Health to expand programming and opportunities, and improve the quality of life, for its priority clients.

Yet the needs of adults with serious and long-term mental illness and children with severe emotional disturbance remain the same: priority clients need access to state of the art treatment, they need homes, jobs, and training, education and supportive personal relationships. Their families need support.

The mental health community, including consumers, professionals, families and advocates, has learned a great deal during the last decade about which programs and services work. New medications are available that help not only to ameliorate the symptoms of severe mental illness, but also assist consumers with the disability imposed by their illness; home-based care for children has proven to be much more effective than costly residential treatment programs; and rehabilitation and support programs that help consumers develop work and living skills have been found to work better than the costly institutional living provided at state hospitals.

Severely mentally ill people have the same hopes and aspirations that most people have: to live in a home, have friends, go to school or have a job that is meaningful and self-sustaining. Our consumers want the support to do these things and are asking for services that help them learn skills to support their independence.

The Plan which follows describes the kinds of services that are critical to ensure the best possible care for seriously and long-term mentally ill adults and severely emotionally disturbed children - the kind of care that enables them to be as independent as possible, delivered by a system that is consumer driven.

This Plan was developed as part of an ongoing planning process mandated by P.L. 99-660. The 40 member Planning Committee, established in June, 1989 to oversee the implementation of this federal law, created subcommittees on adult mental health, child/adolescent services, minority access, human resources, finance, and legal/human rights. Planning Committee members, of whom half are consumers, met with many interested parties within the mental health community - consumers, professionals, family members, advocates and providers - to discuss the needs of mentally ill people and what services are needed. The Committee heard from more than 1300 primary consumers at 10 public forums, statewide, regarding their ideas on how the mental health system should work. Hopefully, the document which follows reflects the consensus of participants about what severely mentally ill people want and need to be productive members of their communities.

But, you might ask, how do we accomplish the tasks set forth in this Plan during a period of significant transition and diminishing resources? It is a challenge, but not an impossible one. As noted in the Plan, several initiatives are already in place to maximize (non-tax) revenues which, in turn, reduce the Department's reliance on state appropriations. Governor Weld has described some far-reaching reforms in his "Financial Recovery Act." The values and goals outlined in this Plan are consistent with the strategies of the Governor's financial recovery plans. Some of the methods outlined in the Governor's plan are innovative and challenge the mental health community to unite creatively to achieve certain goals.

The values and goals shared in this Comprehensive Mental Health Service Plan that support housing options for people with severe mental illness are within reach. The values and goals that support effective inpatient treatment can occur within the context of downsizing state-operated inpatient facilities and looking at private sector options discussed in the Weld/Cellucci Fiscal Recovery Plan. In short, the values and goals remain the same but the methods we select will be different.

The mental health community must maximize the opportunities to provide consumers with those services which help them to be as independent as possible. This philosophy is consistent with the need to continually assess whether the services offered are enabling ones. Are the methods of housing people the most productive? Are the methods of clinical treatment the most effective? Do the ways in which we ask mentally ill consumers to spend their days produce an outcome that meets the twin goals of independence and efficient use of human and financial resources? Certainly, these are questions we can answer as we downsize our inpatient facilities and expand housing, educational and work opportunities for consumers.

This time of transition presents significant challenges for us all - but they are challenges we can meet and use to better serve the priority clients of the Department.

Henry Tomes, Ph.D.
Commissioner
May, 1991

INTRODUCTION

This edition of the Department of Mental Health's Comprehensive Mental Health Plan builds on the Plans that have preceded it and extends the vision of a system that is designed to serve the estimated 22,000 seriously mentally ill adults and 35,000 seriously mentally ill or severely emotionally disturbed children and adolescents in the Commonwealth who need publicly supported mental health services.

The passage of P.L. 99-660, which mandated that states submit detailed, comprehensive plans to the National Institute of Mental Health on an annual basis, provided an opportunity for an organized planning effort to accomplish that task.

In June, 1989, a 40 member Planning Committee was established which included consumers, family members, professionals, state agency representatives, providers and legislators. Subcommittees were formed to develop working models for the adult and child/adolescent systems and to make recommendations regarding legal/human rights, minority access, finance and human resources. In addition, the Planning Committee was charged with the responsibility to find out from consumers and family members what services they want, what services work best and how the Department can be more responsive to their needs.

As the subcommittees began their work, the Planning Committee, with the support of the Department and the Statewide Advisory Council, sponsored a series of public forums across the Commonwealth to which users of mental health services were encouraged and invited to come and speak out. More than 1300 consumers, family members, advocates and providers wrote or testified in person at one or more of the ten forums held between June, 1989 and August, 1990. It is quite clear that the consumer movement in mental health, which affirms the rights and responsibilities of consumers to ensure choice by participating at all levels of the service delivery system, is alive and growing in Massachusetts.

As this edition of the Plan is presented, the Commonwealth and the Department are experiencing difficult times financially. DMH has taken its share of cuts and there is no denying that there are clients suffering because of those cuts. But we can't lose sight of the progress that has been made, both philosophically and really, toward the goal of establishing a mental health system that is responsive to the needs of the people who use its services. It is our hope that this Plan reflects that vision.

Judi Chamberlin, Co-chair
Planning Committee

Bernard Carey, Co-chair
Planning Committee



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CHAPTER ONE

MISSION

Mission

The primary mission of the Massachusetts Department of Mental Health (DMH), is to provide for services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness. This is required by Massachusetts General Laws, Chapter 19. To achieve this mission the Department has identified, as its priority clients, adults with long-term or serious mental illness and children with or at risk of serious mental illness or severe emotional disturbance. By providing its services, the Department hopes to achieve maximum reduction or remission of symptoms, maximum reduction of disability, maximum increase in functioning, and maximum increase in independence for its priority clients, as described above.

To provide a balanced system of care, the Department operates or oversees a comprehensive area-based network of community mental health services. Included are emergency, inpatient, case management, skill development and employment, outpatient, residential, and family and community support services for adults and children. DMH also provides special services, as well as access to existing mental health services, for elders, the deaf, the homeless, refugees, immigrants, cultural and linguistic minorities, individuals who are both mentally retarded and mentally ill or medically involved and mentally ill, and for substance abusers who are mentally ill. In addition, the Department supports training of professionals and para-professionals to work with its clients.

The Department makes every effort to coordinate its service system with the private mental health system as well as with public and private social service, educational, medical, vocational and long-term care provider systems in the Commonwealth to ensure the most efficient use of resources. The Department currently maintains interagency agreements, joint projects or memoranda of understanding with: the Departments of Social Services, Mental Retardation, Public Welfare and Public Health; the Massachusetts Rehabilitation Commission; the Executive Offices of Elder Affairs and Communities and Development; the Rate Setting Commission; and with numerous individual non-public general and psychiatric hospitals.

The Department works with members of the mental health community and others to educate the general public about mental illness and to eliminate the stigma that is associated with it.

In keeping with its programmatic focus on consumer empowerment, psychiatric rehabilitation and services delivered in normative environments, the Department seeks to increase opportunities for participation by primary consumers and family members in policy decisions and in the planning and delivery of services.

Vision and Operating Principles

Vision

The Massachusetts Department of Mental Health has the responsibility to serve adults with serious or long-term mental illness, and children with serious mental illness or severe emotional disturbance in a service system that is responsive to the needs of these individuals and their families. In addition to its statutory mission, and the incorporation of certain fundamental components in its vision for a high quality mental health system, the Department's Comprehensive Mental Health Service Plan is built around a set of operating principles that drive the development and implementation of the Department's policies.

Adults with serious or long-term mental illness and severely emotionally disturbed children and adolescents share the same basic human needs, aspirations, and desires, as well as the same rights, privileges, and responsibilities, as all citizens of the Commonwealth.

Individuals with serious or long-term mental illness or severe emotional disturbance are unique individuals with varied and changing needs and capacities.

Individuals with serious or long-term mental illness or severe emotional disturbance can and should expect the opportunities that all citizens have to lead productive lives in the community, go to school, and find work that is meaningful.

Operating Principles

The Department of Mental Health:

- continues to strive for a comprehensive community-based system of care that promotes psychiatric rehabilitation for adults and home-based services for children and adolescents;
- will ensure that the legal and human rights of consumers are considered and protected in the carrying out of every DMH policy and in the establishment of every DMH operated or contracted program;
- recognizes the differences between the needs of adults and children or adolescents in planning for and carrying out its policies and programs;
- will address the special needs of consumers who are also homeless, deaf or hard of hearing, dually diagnosed or elderly, or lack access to services because of cultural barriers;
- supports the active participation of consumers and family members in DMH policy and planning efforts;
- will work to develop a human resources plan that supports and enables consumers to participate as both service providers and policy makers;
- will continue to collect and disseminate data and develop management information systems that enhance DMH's ability to effectively plan for, adjust to, and match service delivery to locally assessed needs;
- strives for efficiency and accountability in all DMH operations to ensure that funds are maximally targeted for priority clients; and
- will work to increase the amount of revenue DMH is able to collect and retain to maintain appropriate levels of direct service to clients.

Components

While its principles are the foundation upon which a system is built, the following fundamental components are the key ingredients, without which a high-quality system cannot exist.

A high-quality mental health system:

- recognizes and respects the basic human **dignity** of each individual receiving services;
- protects the **legal** and **human rights** of each client and preserves freedom of choice in treatment options;
- provides the highest quality of **clinical treatment**, based on current standards of care and medical and psychiatric advances;
- assists each client to reach his or her highest potential and maximum level of **independence**;
- assists children and adolescents with mental illness or severe emotional disturbance to take full advantage of their talents and capabilities, so that they may reach their **greatest potential**;
- seeks to **empower** each client to compensate for the effects of his/her illness with services geared to that individual's unique and changing needs and abilities;
- **invests** in each client for the duration of his/her illness and recovery and consistently perseveres to find the optimum mix of services for each client, including those clients who may be resistant to intervention and those who may require an individualized mix of treatment approaches;
- **reaches out** to individuals who otherwise may not have access to services;
- **involves, empowers, and supports** family members and other members of each client's natural support network through involvement in treatment planning based on the consent of the client, education, advocacy, support of self-help organizations and direct services such as respite care;

- provides **appropriate education, training and support** for staff, enabling them to provide appropriate services in an environment that supports, respects, and empowers the individuals they serve;
- offers a **range of services** which are **relevant, comprehensive, coordinated, flexible** and offer **barrier-free access**;
- offers a range of services which are **age-appropriate, culturally and linguistically appropriate, least restrictive**, and meet **accepted quality of care standards** such as those of the Joint Commission for Accreditation of Health Care Organizations and the federal Department of Health and Human Services;
- advocates for a **system of support services** to meet the basic needs of people with mental illness to live in the community, including the development of decent housing, adequate income supports, and employment and educational opportunities;
- provides **effective management** that maintains the competencies of its employees, insures the productivity and relevance of its services, and monitors the costs and utility of its programs;
- fosters better **understanding of the causes and treatment of mental illness** through community education; and
- ensures the **quality and appropriateness** of mental health services by sponsoring appropriate licensing, quality assurance, utilization review, and research activities.

A system based upon these principles, and built with these components, will be a mental health system which provides optimum services for people with mental illness in the communities of Massachusetts. The Massachusetts Department of Mental Health aspires to create such a system.

Priority Population

Historically, the Department of Mental Health has sought to provide a broad range of mental health services to citizens of the Commonwealth needing mental health care or treatment. While Chapter 599 of the Acts of 1986, which created separate Departments of Mental Health and Mental Retardation, reaffirmed the broad mandate of DMH, it specifically states that "the primary mission of the Department shall be to provide services to citizens with long-term or serious mental illness, early and ongoing treatment for mental illness, and research into the causes of mental illness."

In order to properly define DMH priority clients and establish appropriate criteria for targeting mental health services to them, the Department convened a task force of consumers, family members, mental health professionals, advocates, providers, other state agencies and DMH staff to draft a policy on eligibility criteria for DMH priority clients. The policy (#89-3) was adopted in April, 1989.

Adults with serious or long-term mental illness and children and adolescents with serious mental illness or severe emotional disturbance are priority clients of the Department. Eligibility criteria have been developed to ensure access to intensive or long-term services by individuals with the most severe impairment. Emergency, crisis intervention and short-term services are available to any individual who is experiencing a mental health crisis.

Priority clients are determined based on factors including the presence of a major mental illness or severe emotional disturbance, the severity of that illness as indicated by level of functioning and the duration of that illness.

Adults who have long-term or serious mental illness have a substantial disorder of thought, mood, perception or memory that grossly impairs judgment, behavior, capacity to recognize reality or the ability to independently meet life support needs of food, shelter, clothing, income and health care.

Children and adolescents, under 19 years of age, who have a severe emotional disturbance with resulting functional impairments, are also the Department's priority clients. They have diminished capacity to reasonably and accurately perceive the world around them, to learn to control their impulses or to maintain satisfying relationships with others.

While the Department maintains its commitment to providing crisis intervention, short-term evaluation and treatment to persons experiencing a mental health crisis, only priority clients will have access to the full range of services.

CHAPTER TWO

SETTING THE STAGE: THE PLANNING PROCESS

P.L. 99-660

A Comprehensive Mental Health Service Plan for Massachusetts

Initiatives undertaken by the Administration, the Executive Office of Human Services, the Department and the Legislature since 1983, such as the Mental Health Action Project, the Governor's Special Message on Mental Health, the Capital Plan, Executive Order 244 and Chapter 599 Acts of 1986, have had a significant impact on the shape and focus of the mental health service system and provide a progressive framework for the Comprehensive Mental Health Service Plan planning process required by P.L. 99-660, enacted by Congress in 1986.

P.L. 99-660 requires each state to implement a community-based system of care for seriously mentally ill citizens and to prepare an annual Plan that specifies goals and documents actions taken to move the state toward a system that reduces the use of inpatient facilities and maximizes community resources. Massachusetts has used the P.L. 99-660 planning process to develop and move toward implementation of both adult and child/adolescent model systems of care. States' Plans are expected to be fully implemented by September, 1992.

The Special Message

The Special Message in 1985 proposed major improvements to community services by expanding case management services, emergency services, access and support, and management accountability. It acknowledged that those with serious mental illness who are experiencing acute symptoms and need to be hospitalized, as well as those waiting for community placement or receiving specialty care, deserve to be treated in facilities that are safe, adequately staffed and humane. It further recognized that access to appropriate housing in the community of one's choice is an essential component of treatment and recovery. These principles led to the development of a \$340 million Capital Plan, approved by the Legislature in December, 1987, to provide funds to upgrade inpatient facilities and increase the numbers of housing units in the community.

To date, the Special Message has added more than 1,100 units to the Department's housing stock. There are an additional 1,000 units of housing in the Special Message development pipeline yet to come on line. The Department has relied on its partnerships with the Executive Office of Communities and Development, the Division of Capitol Planning and Operations, the Massachusetts Housing finance Agency and the federal Department of Housing and Urban Development to fund this development.

The Executive Office of Health and Human Services is supportive of these housing initiatives and has established a review process to streamline the regulations. This effort should speed up the delivery of additional housing units.

Implementation of Executive Order 244

DMH has privatized its inpatient service system for children and adolescents. Through a combination of contracts with hospital providers, general hospital psychiatric bed development, and a Memorandum of Understanding with eight Massachusetts private psychiatric hospitals, the 1300 children and adolescents previously admitted to adult wards of state hospitals now receive age appropriate treatment in certified facilities. Currently, the only state run hospital for children is the Gaebler Children's Center in Waltham, which is targeted for certification during FY'92.

Chapter 599 Acts of 1986

Significant advocacy culminated in a legislative initiative in 1986 (Chapter 599) to split the Department of Mental Health into separate departments of mental health and mental retardation. Effective July 1, 1988, this legislation institutionalized the new mission for the Department as articulated in the Governor's Special Message to "provide for services to citizens with long term or serious mental illness, early and ongoing treatment for mental illness and research into the causes of mental illness." In 1989, after a lengthy and inclusive process that involved consumers, family members, advocates and mental health professionals, the Department promulgated its policy on priority clients which further elaborates on the Department's mission and targeted service population.

Capital Improvements/Current Status

Progress toward achieving the goals of the Special Message and the Capital Plan have been partially realized. Emergency, case management, family support, day, and vocational services were increased. Staffing levels in inpatient facilities were increased significantly and more than 1,100 new units of housing have been brought on line since 1987.

Through the Division of Capital Planning and Operations (Executive Office of Finance and Administration), in collaboration with the Department,

masterplan studies were funded and completed and the design process initiated at Medfield, Northampton, Westborough, and Taunton State Hospitals and the Gaebler Children's Center. Masterplans will be completed in FY'91 for Worcester/UMass Medical Center, Danvers and Metropolitan State Hospitals and the MetroBoston Regional Inpatient Facilities.

Under the initial Capital Plan, prepared in 1987, planned capacity for all the state operated hospitals and community mental health centers was 1,969 inpatient and 553 residential beds. Residential beds at these facilities serve individuals who no longer require hospital-level care but for whom there is no appropriate community placement.

Certain small-scale projects, "priority improvements" such as roof repairs, heating and cooling system repairs, fire alarm installation and other life/safety repairs, were put on an accelerated schedule and have been completed at many of the facilities. These improvements have significantly increased the quality of inpatient environments.

Significant reductions to the DMH budget during the last two fiscal years have seriously impeded progress the Department was making toward increasing community housing opportunities. Continuing fiscal difficulties in the Commonwealth combined with a strong interest in maximizing the Department's ability to serve the most seriously ill clients have necessitated a re-evaluation of the plans to renovate DMH inpatient facilities. It is anticipated that planned inpatient capacity at DMH operated facilities will be reduced.

The Governor's Special Commission on Facility Consolidation, a 17 member panel that includes the Commissioners of the Departments of Mental Health, Mental Retardation and Public Health as well as several legislators, members of the administration, human services experts and a family member, was convened early in April to prepare recommendations to the administration relative to the consolidation and closure of various state institutions. The Commission must develop objective criteria against which to judge its recommendations. These criteria would likely include such issues as appropriate care settings for patients, cost effectiveness and economies of scale, and geographic considerations for patients and their families. The Commission will submit its report to the Governor in May, 1991.

Although specific plans for renovation of the state hospital campuses are on hold pending the report and recommendations of the Commission, Metropolitan State Hospital is being currently downsized from 440 to 120 beds (by June, 1992). Locating appropriate housing in the community for

many of the Metropolitan patients is an active component of the downsizing plan. Some of those who need continued hospitalization will remain at the facility and some will be transferred to other appropriate facilities depending on such factors as age, diagnosis and ties to the community.

A Balanced System of Care

In carrying out its planning, the Department recognizes that mental illnesses are cyclical and that a balanced system of care that takes the cyclical nature of mental illness into account is essential to adequately and appropriately meet the needs of clients who may be in various stages of recovery. This recognition has led to a new emphasis on psychiatric rehabilitation as a complement to effective clinical treatment to ensure that upon discharge from an inpatient facility after an acute episode, clients have access to individualized support services in the community that enable them to retain and further develop gains already made. Emphasis has also been placed on family-based treatment for children and adolescents. Case Management services, which link the most seriously disabled clients with clinical, vocational, social and residential services in the community, are the centerpiece of a balanced care system.

Service Quality

Targeted improvements in inpatient services, both in the quality of the physical environment and in the quality of services provided has resulted in the accreditation of Medfield State Hospital by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the federal certification of units at Westborough and Taunton State Hospitals by the Health Care Financing Administration (HCFA). In addition, four Community Mental Health Centers are accredited by JCAHO and five are certified by HCFA. Five DMH Intensive Residential Treatment Programs were accredited by JCAHO during the last six months and will be able to generate revenue under the "Psych Under 21" Medicaid Program.

The Department has had a goal over the last three years to achieve accreditation and certification of all its hospitals. Budget reductions have made this task more difficult but the Department is still proceeding with plans to achieve this goal.

The following chart reflects current and proposed accreditation/certification status for DMH facilities:

Inpatient Facilities	JCAHO Accredited	HCFA Certified*
Danvers		By 09/01/91
Gaebler		By 09/30/91
Medfield	11/16/89 - 3 years	By FY'92
Metropolitan State		N/A
Northampton	By 08/01/91	By **
Taunton	By FY'92	02/22/91
Westboro		01/05/91
Worcester		By 10/01/91
Solomon CMHC (Lowell)	01/31/90 - 3 years	11/15/90
Corrigan CMHC	02/12/90 - 3 years	11/08/89
Quincy CMHC	06/09/90 - 3 years	10/24/90
Pocasset CMHC		By 06/01/91
Mass. Mental Health Ctr	By 2/28/92 re-accred.	02/21/91
Solomon. Carter Fuller (Boston)	By FY'93	By FY'93
Lindemann CMHC	By FY'93	By FY'93
Bay Cove CMHC (at Lemuel Shattuck)	12/15/88 Thru Lemuel Shattuck Hospital/DPH	09/07/90

* HCFA Certification is always awarded for one year.

** Possible life safety code deficiencies may preclude certification.

Appropriate Use of Inpatient Facilities

Adults, children or adolescents who, after evaluation, are determined to be in need of hospitalization, will be admitted to an inpatient facility. However, if it is determined that an individual may benefit from a less restrictive therapeutic environment, efforts will be made to place that person in the most appropriate setting.

The Department has undertaken a number of initiatives to ensure more appropriate admissions to its inpatient facilities. Other initiatives are currently underway. As a result of expanding and improving community programming and restricting admissions only to those who meet priority client criteria, adult admissions to DMH inpatient facilities decreased by 30% from FY'86 to FY'90. The current census reflects a decrease of approximately 170 adult patients during that time.

Initiatives

- DMH and the Department of Mental Retardation (DMR) have agreed on a process to place 193 long stay mentally retarded individuals who do not require inpatient psychiatric care into appropriate placements outside the mental health system. There is a \$5 million reserve in the FY'91 budget to accomplish this.
- DMH is working to develop 500 accessible inpatient beds for adults in private and voluntary general hospitals. Of this number 200 new beds are on line. Another 100 - 200 beds have been approved for development. However, hospitals are re-evaluating their willingness to bring these beds on line under the current financing system. Reimbursement issues that affect a hospital's willingness to develop psychiatric beds are currently under review by the Rate Setting Commission and DMH through a joint study. The data produced by the study will enable the Department to advocate strongly for appropriate language to recognize the higher costs associated with psychiatric services and the need for a new rate structure to be included in successor health care legislation needed to replace the existing hospital financing legislation due to expire September 30, 1991. Current legislation makes it unprofitable for general hospitals to develop or convert beds for psychiatric use for DMH priority clients who frequently require a higher staff to patient ratio and a longer length of stay.
- Legislation was passed guaranteeing access to a minimum of 30 beds within private psychiatric facilities for children and

adolescents who are DMH clients. Sixteen additional beds are obligated to DMH through the state's regular Determination of Need process. Since 1985, 62 new beds in general hospitals have come on-line and 41 additional beds are being developed. It has therefore become unnecessary for the state to develop additional state-operated beds for children or adolescents.

- DMH revised and implemented admission criteria and voluntary hospitalization policies to ensure that inpatient care is targeted to adults with long term or serious mental illness and children and adolescents who are seriously mentally ill or severely emotionally disturbed. The admission rate for adults per 1000 population decreased from 2.171 per thousand in FY'86 to 1.513 in FY'90.
- DMH developed more appropriate monitoring and reporting mechanisms for admission, utilization and discharge statistics to assist in reducing inpatient utilization.
- Program standards are being developed to provide for a holding or respite capacity in each Area to divert unnecessary admissions and provide appropriate clinical interventions.
- DMH staff are monitoring hospital use and residential stay of children and adolescents to prevent unnecessary admissions and overly long lengths of stay. A prescreening team must approve all hospital admissions.
- The creation of a Mental Health Inpatient Insurance Task Force was approved by the Legislature in the FY'91 budget to examine the statutory mandated mental health inpatient benefit. When activated, the Task Force will study and then recommend policies and procedures to create greater flexibility in the interpretation of the current benefit including services that are clinically appropriate and cost-effective alternatives to hospitalization.
- The Department has developed procedures in each Area to consistently generate an unduplicated list of inpatients in DMH facilities who are waiting for community placement to support census management and reduce inpatient hospitalization.
- The Department has developed a database to facilitate tracking and effective planning for the group of consumers who are mentally ill/medically involved (MI/MI). Working with other state agencies, DMH collaborated in the development of Farren Care Center (FCC), a

private nonprofit 110 bed skilled nursing facility specializing in the care of MI/MI individuals, and will be able to place 77 patients at FCC during 1990-1991 from its own inpatient units and community system. During FY'90, 75 MI/MI patients were discharged from inpatient units and placed in more appropriate community settings.

- DMH made a commitment to initiate and fund a program of treatment with a new anti-psychotic drug, clozapine, for individuals within the DMH hospital system who meet FDA criteria. Although the impact of treatment cannot be determined for at least a year, consumers and family members are optimistic and expect that a significant number of priority consumers will be able to live successfully in the community, decreasing the eventual need for some hospital wards.
- DMH is negotiating with the Department of Public Health to open an 80-90 bed mental health unit in a Public Health Hospital. This will accomplish two objectives: relieve overcrowding at some facilities; and create a fully reimbursable psychiatric inpatient unit within accredited space.

Secure Services Plan

The Department has recently developed the capacity to provide treatment to patients who require a secure setting. In the past, DMH transferred behaviorally difficult mentally ill adult male patients to Bridgewater State Hospital, the state's maximum security psychiatric hospital administered by the Department of Correction. Because of concerns regarding the appropriateness of treating civilly committed mentally ill men at Bridgewater State Hospital, legislation was passed requiring that the Department stop the transfer of civilly committed clients to Bridgewater and return to its care those patients who had been transferred to Bridgewater. As of December, 1990, the Department had accomplished the following:

- opened a new unit at Medfield State Hospital that is both staff intensive and physically secure to provide an appropriate clinical setting for patients who are behaviorally difficult;
- increased staffing to better manage behaviorally difficult patients at state hospitals;

- transferred all DMH civilly committed clients who were being treated at Bridgewater State Hospital to the Medfield State Hospital secure treatment unit and, when clinically appropriate, to other DMH facilities.

As part of the Capital Plan, future plans include the development of inpatient units for difficult to manage patients that will provide the security needed to prevent and manage patient violence.

Planning Committee

A Planning Committee, established in June, 1989 to oversee the P.L. 99-660 planning process, consists of 40 members. Half are consumers or family members, and half represent state and private agencies and professional or lay organizations that have a significant interest in mental health service delivery in Massachusetts.

Sub-committees, established by the Planning Committee, have met regularly to focus on six separate, specific areas. They are: **Legal/Human Rights, Minority Access, Adult Services, Child/Adolescent Services, Human Resource Development and Finance.** The goal of the sub-committees has been to further refine the adult and child/adolescent service models and to incorporate within those models recommendations to address legal and human rights, minority access, human resource development and finance issues.

CHAPTER THREE

KEY PLANNING ISSUES

Psychiatric Rehabilitation

The P.L. 99-660 planning process has enabled the Department to focus on key philosophical and programmatic issues that represent its vision for the future of mental health in the Commonwealth. Paramount among these issues is the appropriate relationship between treatment and rehabilitation within a comprehensive service system.

Currently, the Department views treatment as the medical, psychiatric component of care. Treatment is the driving force in reducing the disabling symptoms of mental illness, through medication and therapy. Rehabilitation develops skills and supports to enable an individual to achieve an optimal level of functioning in employment and independent living. During the past two years, the Department has pursued efforts to broaden its services to reflect a greater emphasis on psychiatric rehabilitation. The goal of rehabilitation services is to enable persons with a psychiatric disability to achieve their greatest level of independence.

A committee of DMH staff, consumers and other professionals collaborated on the Rehabilitation Project and presented the Commissioner with a model for his consideration in June, 1990. The basic mission of the model is to empower and assist DMH priority consumers to develop the skills and gain access to the resources necessary to choose, gain and maintain meaningful work, a stable home, a social support network and an education and to appropriately integrate both treatment and rehabilitation in the Department's approach to service delivery.

Given appropriate and accessible community services, persons with long term or serious mental illness can generally live in the community and become productive members of society. However, the service system must be flexible enough to respond to the changing needs of consumers who may suffer from cyclical illness and need hospitalization or some sort of crisis intervention or respite as an alternative to hospitalization. Additionally, high functioning consumers may not progress to the best of their ability if the level of care is too restrictive for them. Finally, some consumers may be able to live on their own, but the majority of them will require some support to help them maintain their independence. The Department's challenge is to offer a comprehensive service system that can adapt to clients' successes as well as to their temporary setbacks.

The Rehabilitation Project at DMH has established a framework within which to implement the above objectives. Numerous in-service training activities have taken place for DMH and provider staff, consumers, family members and staff from the Massachusetts Rehabilitation Commission on rehabilitation theory and practice and more are planned for this year.

However, when attempting to implement a new philosophical approach to treatment, it is necessary to recognize and be sensitive to the dynamic tension that exists among staff, consumers and others who have different orientations toward treatment and rehabilitation of people with serious mental illnesses. These differences must be worked out through a process that is respectful of the difficulties involved in incorporating systemic changes.

Consumer Involvement

During 1989-1990 the Planning Committee sponsored ten consumer forums across the state, including a statewide consumer conference attended by 350 people at Framingham State College in June, 1990. Two forums were specifically focused on child/adolescent services. Over 1300 consumers, family members, mental health professionals and advocates participated in these forums. Oral testimony as well as written comments provided the Committee with feedback about the perceived level and quality of mental health services in the Commonwealth and recommended areas for change and improvement. Among the strongest recommendations, in addition to requests for increased housing and employment opportunities for people with serious mental illness and for culturally appropriate services, was the consumers' desire for active and ongoing participation in planning, policy development and program operation.

In December, 1990, the Planning Committee co-chairs hosted a roundtable discussion with consumers to think about next steps. Consumers made it clear that they want and need to be more actively involved in mental health service delivery. They are eager to work collaboratively with the Department to develop a systematized way to provide for consumer input in order that consumers are consulted before policies are set. Other strong consumer interests are in the areas of peer counseling, training of professional and non-professional staff and in establishing a statewide communication network among consumers.

Several ongoing consumer support activities provide supportive and educational services to people who have long term mental illnesses. The consumer support activities focus on the development of the leadership

and peer support skills of primary consumers. In addition to funding fifteen community support clubhouses statewide (ten more are being developed) the following services and activities are currently being provided:

*M*POWER (Massachusetts People/Patients Organized for Wellness, Empowerment and Rights)*

M*POWER is a statewide organization of primary consumers who are working to address the stigma of mental illness. Consumers learn how to chair meetings, speak in public, give presentations at workshops, do effective outreach to other consumers, develop effective strategies to address stigma, provide peer support, work cooperatively as members of a decision-making group, participate in policy making activities and negotiate with public officials. M*POWER currently has two local chapters, in Lowell and Boston, and recently started a statewide organization with at-large members.

Ruby Rogers Drop-In Center

The Ruby Rogers Center is a self-help drop-in center run entirely by primary consumers. As staff members, consumers learn how to handle the agency's finances, deal with hiring, firing and staffing issues, and support their peers in times of crisis and on a day to day basis. The Center also provides advocacy and information for consumers and former psychiatric patients.

Independent Living Demonstration Project

Independent Living Centers (ILCs) are federally mandated to serve people with physical as well as psychiatric disabilities. However, most of these facilities have not focused on the latter population. In 1987, the Department conducted a statewide study to assist ILCs in meeting their federal mandate to provide independent living services to people with psychiatric disabilities. Since 1988, the Department has funded a project at the Northeast Independent Living Center in Lawrence as a pilot for future ILCs in Massachusetts. Funding has not materialized, however, for expansion to other ILCs in the state.

The Mental Health Project provides a forum for primary consumers to develop leadership skills. The skills are developed as consumers

participate in activities aimed at: training mental health practitioners to act in more empowering ways to their clients; educating the community about the stigma of mental illness; and providing peer support to other consumers. The peer discussion/support activities include organizing around such topics as medication support groups and eliminating the internalized stigma that many consumers feel.

In addition to discussion/support groups, the Project holds consumer conferences and is developing a working theory of recovery and empowerment: what helps and what hinders. The theory is intended to be used as a guide for consumers to use as they move through their own recovery process, and for professionals to use as they work to support those trying to recover.

The Independent Living Project is currently seeking funding for several pilot projects aimed at assisting inpatient consumers to advocate for themselves during the process of developing their Individual Service Plans, and to address the stigma of mental illness through media watch activities.

Parent/Professional Advocacy League (PAL)

PAL is an organization of parents and professionals working together to : improve parent-professional understanding and collaboration; empower parents of emotionally disturbed youth to serve as partners with professionals through education, information sharing and mutual support networks; and promote effective advocacy for emotionally disturbed youth and their families. PAL supports the development of self-help/advocacy groups throughout the state to achieve its goals.

Statewide Consumer Preference Survey

313 primary consumers and 400 family members were interviewed for this survey conducted by twenty primary consumers who were hired and trained to conduct the interviews. Consumers who participated in the survey signed consent forms provided to them by their case managers and were interviewed face to face. Family members were located in several ways. Some were contacted after permission had been obtained from DMH clients, and others were contacted through a mailing list provided by the Alliance for the Mentally Ill. Family members who participated were mailed a written questionnaire.

The data from both groups are currently being analyzed. A written report of the project will be disseminated within DMH and to the community at large. An attempt will also be made to publish the data. It is expected that the findings will be used in ongoing DMH policy decisions.

Coalition of Clubhouses

Members of clubhouses in Massachusetts have formed a planning group to start a coalition of Fountain House model clubhouses. Eighteen clubs are currently participating. The Coalition protested the recent budget cuts to the Department to the Governor and the Commissioner and were successful in having \$500,000 restored for clubhouses. The Coalition has also held a training session to teach members how to chair meetings. The group is currently working to further define its goals.

The Status Report on the Comprehensive Mental Health Service Plan

As required by P.L. 99-660, this report was submitted to the National Institute of Mental Health in September, 1990 and documented the achievements of DMH, to date, in implementing objectives the Department had established in its previous draft Plan of September, 1989. The Status Report also included drafts of the working papers provided to the Planning Committee by the sub-committees in preparation for this current edition of the Plan.

Organizational Structure

In October, 1990, in order to address budget reductions and to ensure the most efficient use of its administrative resources, the Department reorganized its field and central office operations by eliminating separate area, regional and inpatient administrative offices, and consolidating them into nine service delivery areas. Twenty-eight administrative offices were closed across the state. Nine Interim Area Directors were appointed and given the responsibility of integrating the field management structures. At the suggestion of members of various citizen advisory groups who met twice during the fall of 1990 to discuss the reorganization, the Commissioner initiated a search process and nine permanent Area Directors were appointed in March, 1991.

As reorganization is completed, all administrative functions will be consolidated, including personnel, payroll, labor relations, contracts,

budget, accounting and purchasing. There will be a single chain-of-command throughout the community and inpatient systems. A single individual will be accountable for the care of each client, regardless of what services that client is receiving. Local case management sites will be maintained to ensure appropriate access to services.

In addition, the Department moved its entire central office operations to the Erich Lindemann Mental Health Center, a Department of Mental Health facility, in January, 1991.

NEW AREA BOARDS

The elimination of Regions and the reorganization of Areas has necessitated a change in the Department's regulations governing Area Boards. The changes will be accomplished through the regular process of circulating proposed regulations and then holding a hearing and inviting written comments before final regulations are sent to the office of the Secretary of State to be promulgated. This should be accomplished during 1991.

The existing twenty-four Area Boards and community mental health center Advisory Boards will be maintained in some capacity to ensure continued local participation in mental health service delivery. Their exact legal configuration will be specified in the new regulations. Hospital boards of trustees are not affected by the reorganization.

THE NINE AREAS

Western Mass

Northampton State Hospital
Berkshire
Franklin/Hampshire
Holyoke/Chicopee
Springfield/Westfield

Central Mass

Worcester State Hospital
North Central
South Central/Blackstone Valley
Worcester

Merrimack Valley

Lowell/Solomon Mental Health Center
Lawrence/Haverhill-Newburyport

North Shore

Danvers State Hospital
Lynn/E. Middlesex/Tri-City
Danvers/Salem/Cape Ann

Metro Boston

Dr. Solomon Carter Fuller Mental Health Center
Erich Lindemann Mental Health Center
Massachusetts Mental Health Center
Bay Cove Mental Health Center
Cambridge/Somerville

Metro West

Metropolitan State Hospital
Westborough State Hospital
Central Middlesex
Marlborough-Westborough/
South Middlesex

Metro South

Medfield State Hospital
Newton/South Norfolk
Coastal/Quincy Mental
Health Center

Southwest

Taunton State Hospital
Taunton/Attleboro
Fall River/Corrigan Mental
Health Center
New Bedford

South Shore

Brockton
Cape Cod/Pocasset Mental
Health Center
Plymouth

Restructuring of Mental Health Authority

The Department is looking carefully at other states and at national research studies that are attempting to document the use of various local mental health authority structures to achieve the goals of an integrated, community-based system of care for the seriously mentally ill.

In particular, there is some interest in the Robert Wood Johnson Foundation Program on Chronic Mental Illness. The Foundation is in the fourth year of a five year study to "provide support for broad change in the organization, financing and delivery of services in public systems of care for chronically ill persons." Nine sites were chosen nationwide and each was required to create a mental health authority to centralize administrative, clinical and fiscal oversight functions. The Program includes provisions for an thorough evaluation of the outcome to be coordinated by the Mental Health Policy Studies Program at the University of Maryland.

The Massachusetts Alliance for the Mentally Ill is also interested in the research on this topic and convened a task force, in which several DMH staff members participated, to look into other states' models of service delivery and to make recommendations for restructuring in Massachusetts.

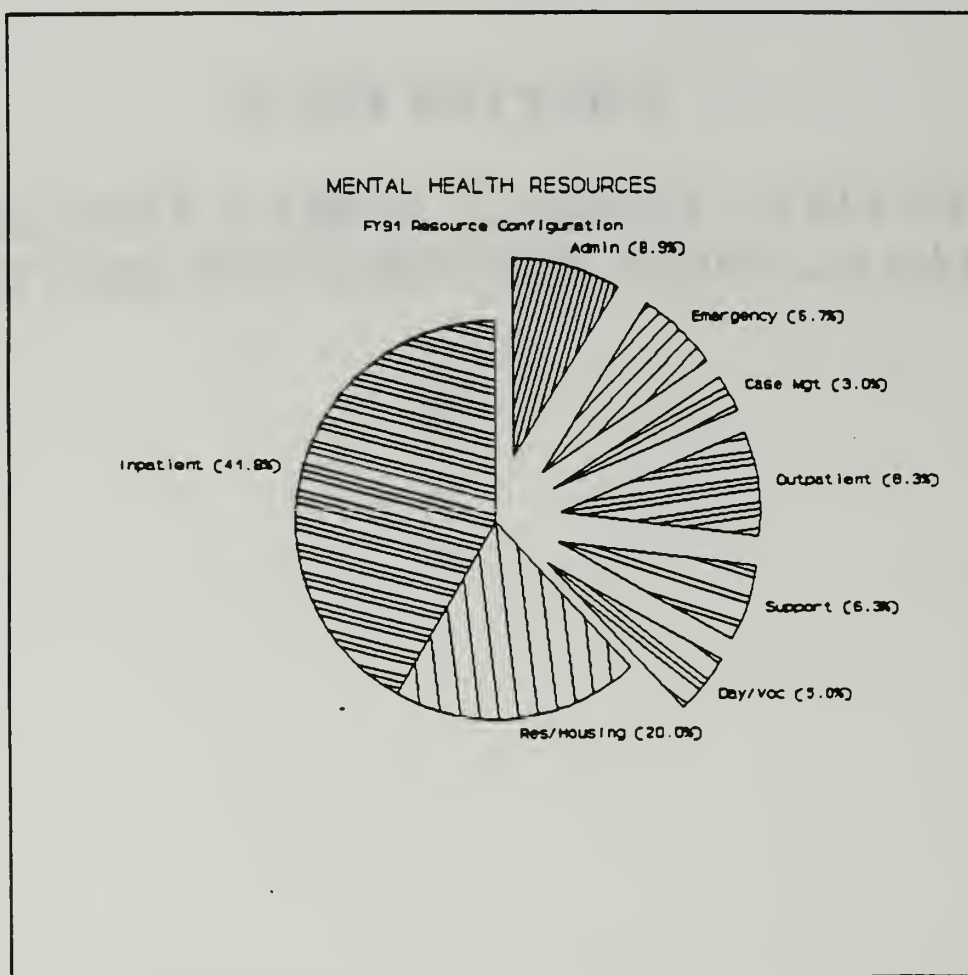
CHAPTER FOUR

OVERVIEW: FINANCE, HUMAN RESOURCES, MANAGEMENT INFORMATION SERVICES

Financing the Service System

Resource Configuration

In FY'91, the Department estimates its total available funding at \$470 million, derived from the sources described in the next section. This funding supports a broad array of mental health services for children, adolescents and adults, as depicted below.



The proportion of resources devoted to each service shown in the chart are taken from the most recent FY'91 Resource Inventory. The proportions are estimates of the distribution of resources taken at a point in time, and do not necessarily reflect final budget cuts or reversions of funds originally appropriated.

Sources of Funding

State Appropriations

The largest source of support for the Department is direct state appropriation. DMH receives annual appropriations from the Commonwealth's general fund into six appropriation accounts. For FY'91, the total appropriation for DMH is \$452.7 million. The Department also projects a transfer from DMH/DMR reserve accounts of \$2.7 million to fund the transfer of patients from DMH facilities to community mental retardation programs, for a total available balance of \$455.4 million. This budget supports approximately 7900 part-time and full-time staff, as well as the majority of contracts purchased by the Department from private vendors.

However, the continuing problems in the Commonwealth virtually ensure there will be further cuts to the mental health system. The Governor and Legislature have withheld or vetoed \$45 million to date in FY'91 from the \$514 million appropriation determined necessary by DMH to maintain services. The \$455.4 million (plus approximately \$31 million in grants and retained revenue) available in FY'91 is substantially less than the amount necessary to continue services in place at the end of FY'90. As a result, since July, 1990, DMH has been required to make significant reductions in staff and services to stay within its state appropriation.

Federal Grants

A second source of funding is grants-in-aid from the federal government. DMH currently receives funds from seven grants, totaling \$10.9 million. The largest source is the DMH portion of the ADAMHA Block Grant, which funds community mental health services across the DMH system. The remainder of the funds support technical assistance and program development as well as 24 technical support and direct care positions.

Federal assistance has been roughly constant in real terms in the last few years. Federal assistance in FY'85 was \$10.0 million.

Revenue

The Department projects revenue collections of \$39.8 million in FY'91. However, much of the revenue goes directly to the state's general fund. DMH must have specific Legislative authorization to spend funds derived

from revenue collection. DMH is authorized to spend 100% of funds collected by its community mental health centers for inpatient and outpatient billing. These funds, estimated at \$7.9 million in FY'91, are used to supplement state appropriations to support ongoing facility operations of the centers. In addition, in FY'91, DMH expects to retain approximately \$5.7 million out of \$7.8 million in collections at the state hospitals, the bulk of which are generated by the adolescent inpatient units.

Since FY'89, the Department has been authorized to retain 100% of revenues generated by Medicaid certified adolescent programs up to a legislatively fixed ceiling. This revenue will continue to be used to offset the cost of adolescent inpatient units and Intensive Residential Treatment Programs and to fund certain other children's programs aimed at reducing inpatient utilization. The FY'91 cap is \$5.5 million and the Governor's proposed budget for FY'92 recommends an increase in the ceiling to \$8 million. However, the recommended state appropriation for children's services was reduced by \$3.2 million, resulting in a net loss of \$700,000 for the Department.

Revenue Strategies

The Department has identified two primary strategies to increase revenues for mental health services in FY'91 and in the next several years:

Billing for Community-Based Services and Certification of Inpatient Units.

Billing for Community-Based Services

The Department has implemented a four phase strategy to increase revenues from community-based mental health services:

- **Case Management Billing**

In FY'89, DMH began billing the federal Medicaid program for case management services previously funded 100% by the Commonwealth. In June, FY'90, the Department sought a rate adjustment which has been approved by the Rate Setting Commission retroactive to FY'89. Based on these new rates, \$14.6 million in federal revenues will be obtained in FY'91, \$10.6 million above the Department's FY'91 target for case management revenues. DMH will retain \$1.6 million of these revenues in FY'91. Annually, mental health case management services are generating

\$8.0 million in federal reimbursement under the new rate as compared with \$4.0 million under the former rate. Rate adjustments are expected to reduce reimbursement to \$7.0 million in FY'92.

- Rehab Option: Residential Services

In September FY'91, DMH began to implement Medicaid billing for residential services provided to adults and children/adolescents under the Rehab Option. DMH and the Department of Public Welfare (DPW) are working cooperatively to implement this project. An interagency agreement was signed September 1, 1990, which serves as the legal basis for billing the federal Medicaid program for DMH services. DPW and DMH have agreed to service authorization and documentation standards which comply with Medicaid regulations. Training of more than 1000 DMH and provider staff on these standards and requirements has taken place. DMH will verify readiness to bill and transmit claims to DPW for service dates from October 1, 1990. Actual billing commenced in March, 1991. DMH estimates conservatively that residential services reimbursement will yield annualized revenues of approximately \$9.0 million. In FY'91, the target set by DMH is \$5.0 million in revenues. These revenues will be credited to the general fund in FY'91.

- Rehab Option: Day Services

In FY'92, DMH will plan for the next phase of billing under the Rehab Option: billing Medicaid for selected day services. The experience gained in billing for residential services should permit rapid implementation of day services billing, although this phase will be more complicated than residential services billing - there are more providers and many different service types. DPW requires that a licensed clinician recommend the service (DMH does not currently require this). Provider records on service authorization and delivery generally do not meet Medicaid standards and will have to be improved.

- IRTP Billing

In FY'91, DMH will obtain certification and begin generating revenues from accredited Intensive Residential Treatment Programs. These programs, which serve as "step down" units for adolescents being discharged from inpatient hospital settings, are expected to yield about \$1.1 million in FY'91 revenue. IRTPs not certified in FY'91 will be certified in FY'92 providing that the costs associated with bringing them up to standards are not prohibitive. These revenues are retained 100% by DMH.

Certification of Inpatient Units

There are three components to this revenue strategy:

- Certification of Inpatient Units

In order to be certified by HCFA to receive federal reimbursements, inpatient units must meet stringent staffing, record-keeping and physical plant requirements. As a result of Special Message funding, staffing levels are generally reaching HCFA standards although budget reductions for FY'91 will clearly hurt these achievements in staffing levels. Record-keeping systems are improving, but are not generally at required levels. Physical plant (life safety) standards fall far short of HCFA requirements at most DMH facilities, although capital improvements funded through the Special Message are targeted to achieving certification/accreditation in all facilities. Until all three requirements are met (staffing, record-keeping, physical plant), DMH facilities cannot obtain federal reimbursements.

In addition, no federal Medicaid reimbursement is allowed for the largest cohort of mental health patients, aged 22-64. For these reasons, DMH has, over the past several years, reorganized its inpatient system to ensure that specialty units serving children/adolescents and geriatric patients are in certifiable space and that staffing levels in these units are not affected by budget cuts.

The chart following this section indicates the number of hospital and CMHC beds certified in FY'90 and additional beds projected to be certified in FY'91. DMH is working to achieve certification of all beds over the next several years. If all inpatient beds were certified, hospitals would generate \$6.1M in incremental revenues and CMHCs would generate approximately \$4.5M additional revenue, given the current age mix of patients and their potential for third-party coverage.

At the beginning of the fiscal year, DMH projected \$9.8M in reimbursement for state hospitals (a 100% increase over FY'90). These projected revenues are contingent upon \$2.0M in new initiatives this year which may be difficult to achieve: \$2.0M in new federal Medicaid and Medicare revenues are conditional on the certification of Gaebler Children's Center and a unit at Worcester State Hospital. At this time, these initiatives are in jeopardy due to the budgetary reductions sustained by the Department. DMH is therefore currently projecting \$7.8M in hospital revenues for FY'91, although efforts to continue to seek certification are proceeding. DMH will retain \$5.7M of these revenues.

\$4.3M in reimbursement for child/adolescent inpatient beds are projected for FY'91. These revenues are 100% retained by DMH.

Approximately \$7.0M in revenues from community mental health centers operated by DMH will be generated in FY'91. These revenues are 100% retained by the Department.

- Medicare Part B Billing/Ancillary Billing

The Federal Medicare program provides both hospital insurance (Part A) and medical insurance (Part B). Psychiatric benefits are quite limited under Part A, but the Part B medical insurance will pay for hospital-delivered ancillary services (i.e. lab, radiology, etc.) when rendered in certified facilities. The Department has undertaken efforts to appropriately document, develop Medicare rates and begin billing the Medicare program for ancillary services delivered in its facilities with certified beds.

In addition, Part B will reimburse for physician visits and the Department is investigating ways to capture revenue for specific patient encounters with facility-based physicians.

There is potential for generating revenue from doctor visits to inpatients even in facilities that do not have certified beds. Efforts are underway at Medfield, Metropolitan and Northampton State Hospitals (locations with a healthy mix of Medicare eligible clients) to initiate Part B billing for physician encounters.

- Linkage of Inpatient Units to Department of Public Health (DPH) Hospitals and Community Hospitals to Achieve Certification and Relocation of State Services to Private, Revenue-generating Facilities.

The Department, in conjunction with EOHHS and other state agencies, has been negotiating with a number of DPH and general hospitals to site specialized services in facilities that meet certification standards and where revenues can be maximized. Farren Care Center, redeveloped into a specialty facility for medically ill/mentally ill nursing home residents, is one successful example. Other examples include Holyoke Hospital's planned 24-bed DMH dedicated adult psychiatric unit, and the Somerville Hospital Project. The acute adolescent unit that was located in uncertified space at Metropolitan State Hospital moved in January to Somerville Hospital, where it will be self-supporting.

The Department has had preliminary discussions with a number of general hospitals to determine the industry's level of interest in arrangements under which an accredited CMHC or certain CMHC services would operate under the hospital's license, and thereby be eligible for Medicaid and other third-party reimbursements. Cape Cod and Lowell General Hospitals expressed a high degree of interest, but both determined that reimbursement for psychiatric services is unfairly treated under the current hospital payment system which is too inflexible to support such innovative relationships. In response to these problems, and to other related issues raised by general hospitals, the Department embarked on a major, joint study with the Rate Setting Commission. This study, which was recently completed in, provides valuable information on the actual costs of providing inpatient psychiatric services to different patient populations, and recommendations for restructuring the hospital payment system so that it better supports the Department's general hospital initiatives. A new hospital payment system must be approved by the Legislature and in place by October, 1991 when the current legislation expires.

Facility Certification Status

<i>Facility</i>	<i>Total # Beds As Of 3/6/91 *</i>	<i># Certified Beds As Of 07/01/90</i>	<i># Potential Additional Certified Beds In FY'91</i>	<i>Total # Certified Beds In FY'91 As Of 2/22/91</i>
Danvers	155	0	0	0
Gaebler**	56	0	0	0
Medfield	172	0	0	0
Metropolitan***	412	0	0	0
Northampton	145	0	0	0
Taunton	344	84 (17 Adol)	47	131
Westboro	358	65 (29 Adol)	86	151
Worcester	362	0	0	0
<i>Subtotal Hospital</i>	2,004	149	133	282
Brockton	NA	NA	NA	NA
Corrigan	32	32	0	32
Bay Cove	65	65	0	65
Fuller	65	0	0	0
Lindemann	40	0	0	0
Mass. Mental	47	47	0	47
Pocasset	33	0	0	0
Quincy	21	21	0	21
Solomon	46	46	0	46
<i>Subtotal CMHCS</i>	349	211	0	211
<i>DMH TOTAL</i>	2,353	360	133	493

* sq. ft., not staffed capacity

** anticipate downsizing to 42 beds by July, 1991

* * * anticipate downsizing to 220 beds by June, 1991 and to 120 beds by June, 1992

Human Resources

Since the initiation of the Department of Mental Health's P.L. 99-660 Comprehensive Mental Health Services planning process, numerous agenda items have been introduced in the arena of human resource management. These planning items range from cost containment measures to areas more directly related to service delivery models and principles being formulated in other P.L. 99-660 planning subcommittees. However, several central themes have emerged consistently. It is these central themes which provide the foundation for the human resource-related goals contained within this plan and which are outlined below:

- Training for the caregivers of seriously mentally ill adults should reflect the psychiatric rehabilitation model. Training for caregivers of seriously mentally ill and severely emotionally disturbed children and adolescents should reflect a focus on ways of keeping children in the community including home-based treatment. This training should be delivered consistently throughout the state operated and vendor-based service systems, and must be comprehensive enough to include families and consumers.
- Consumers must be encouraged to become part of the mental health workforce. Strategies must be developed and implemented that attract consumers to the workforce and support their retention and growth within the mental health system.
- The needs of multicultural individuals seeking mental health services are best addressed by caregivers who understand cultural differences and possess linguistic capabilities sufficient to foster effective communication, instruction, and a climate for treatment and rehabilitation.

Enhanced Training Agenda

Funding shortfalls within the Department of Mental Health have curtailed efforts to upgrade both pre-service and in-service training for DMH employees. Similar shortfalls within the provider community have made it difficult to enhance training opportunities there as well, particularly for line, direct care staff. While it will not be immediately resolved, it is imperative that steps be taken to meet the demand for improved training and that psychiatric

rehabilitation principles are integrated into existing curricula and ongoing practice.

Each of the service delivery models embraced by other P.L. 99-660 workgroups supports community-based programming and the treatment of seriously mentally ill persons in the least restrictive setting deemed appropriate. This contemporary focus mandates that staff be trained in the principles of rehabilitation and home-based treatment and that modules be developed and delivered which specifically reinforce the goals of these new service delivery models.

Beyond the substance of these trainings, it is perhaps more important that this curricula be incorporated in all areas servicing DMH priority clients. The integration of these ideals and practical applications into the orientation and in-service modules for both state and vendor staff are essential to promote uniform services and ensure true continuity of care.

With respect to funding shortfalls, it would appear that the implementation of a uniform training curricula would also support cost-savings initiatives. A standardized training agenda could allow for the development of regional training initiatives or centers of excellence, thus maximizing economies of scale.

Finally, this training product must include a module which stresses the contributions consumers and family members bring to the rehabilitative process. In addition to the secondary services provided to the involved consumers or families, it is clear that this approach is key to the successful integration of the rehabilitative model.

Consumers in the workforce

The consumer forums conducted in conjunction with the P.L. 99-660 planning process provided unique opportunities for consumers to speak out and provide constructive feedback on the type and level of services provided by DMH. A specific and recurring idea emerging from these meetings focuses on the desire of DMH consumers and family members to participate in planning for and active treatment of other consumers, and in the training of existing professional staff.

The unique perspective and experience consumers bring to the mental health system is a resource that must be maximized within the DMH service delivery system. For example there are consumers, who are also clinicians, who run groups for other clinicians and consumers to explore what it is like to be a consumer and working in the mental health system. Another consumer effort focuses on providing training sessions for staff at one of the state hospitals on the issue of human rights from a consumer perspective as well as understanding the difficulties encountered in transitioning from hospital to community. On an individual level, there are consumers in high profile as well as low profile positions throughout the system. In addition to providing important training and support for clinicians and consumers, these efforts provide an important opportunity to combat the stigma surrounding mental illness that still exists, unfortunately, among professionals, consumers, and the general public.

It is recommended that a working group made up of both consumers and DMH senior managers be assembled to develop strategies for increasing employment opportunities for consumers within DMH. This group should forward its recommendations directly to the Commissioner for incorporation into the hiring and staffing plans of the agency's Area Directors. These recommendations should initially address those obstacles to employment of consumers which currently exist within the agency and include strategies for the retention and growth of consumers who are hired by DMH.

The current fiscal climate in the Commonwealth provides unique opportunities for the incorporation of cost-effective recruitment strategies aimed at increasing consumer representation in the DMH workforce. The workgroup should capitalize on these opportunities and examine employment access points in all areas and at varying levels of titles and compensation. Many consumers have expressed an interest in volunteer services as a way to gain experience and confidence. This may be an avenue for access which can be broadened to include both paid and unpaid internships.

It is appropriate and necessary to develop a workplan for increasing consumer representation in the DMH workforce based on the experience and knowledge gained from other states. Massachusetts could clearly benefit by using this largely untapped resource to play a key role in meeting the needs of the seriously mentally ill in the years to come.

Improve access of services to populations of diverse cultures by increasing the representation of multilingual and bicultural staff.

As the agency's management information capabilities continue to grow in the area of client tracking, this data must be utilized in the human resource planning process. Specifically it seems appropriate to examine workforce composition and staffing patterns to ensure that client cultural and linguistic needs are being met. The issue of access for minority populations is being addressed in a more focused manner by another subcommittee. However, it is implausible that access can be sufficiently enhanced without significant revisions to agency workforce maintenance.

All of the strategies presented previously to ensure greater consumer representation in the workforce, including strategies to improve access and retention, are compatible with the activity necessary to improve the representation of individuals with different cultural backgrounds within the employ of DMH. Prospective employees with unique cultural understanding and/or linguistic abilities are needed within the DMH workforce and in its contracted programs. The status of the job market within Massachusetts affords the agency the best opportunity it has had in years to obtain such talent.

To reinforce this effort, it is necessary for the Department to use and analyze available client and census data in new ways. DMH Areas must be made more aware of the cultural and linguistic needs of its clients and develop hiring and staffing plans to address these needs. Such staffing requirements should become a working component of provider contracts and be actively monitored to ensure compliance. Optimal staff representation goals should include specified cultural subgroups and be more specific and inclusive than current policies which target groups such as females, minorities, disabled individuals and Vietnam-Era veterans.

Many human service agencies have aggressive multicultural recruitment plans already in place. Bilingual testing and certification of employees is exercised on both a pre-employment and post-employment basis. The Department of Mental Health must strive to adopt and practice these activities to support the attainment of its mission and to ensure full access and services to all its clients.

Management Information Services

Two priorities of DMH have been the development and standardization of a range of information systems that allow informed decision-making as well as the development of service system standards and performance indicators to allow proper measurement and monitoring of the services provided to consumers. Key components of the information and performance monitoring systems are described below.

Client Information: The Client Registry

Accurate information about the population served by DMH is a cornerstone of effective management. The Client Registry, a statewide on-line system that uses a unique identification number for each client, provides a comprehensive database of selected Department clients.

Currently, the Registry provides basic demographic and financial information about more than 10,000 individuals receiving inpatient, residential, or case management services, or who are on waiting lists for case management services. The Registry has the capacity to be expanded to include other services as well. Plans include registering all individuals in DMH inpatient facilities who are not yet registered.

Service Information: The Client Tracking System

While the Client Registry provides key profile information about clients, it provides very limited information about service utilization. A recently piloted Client Tracking System will provide this critical information and full implementation is expected in FY'91. This system will record admission and discharge information for case managed clients into community and inpatient mental health services, as well as provide a range of clinical and functional information.

This microcomputer application will serve as a prototype for the development of a comprehensive application for the Department and will be integrated with the Client Registry on the mainframe computer.

Inpatient Systems Development

The Department must have data systems in place in its inpatient facilities that provide comprehensive data about the utilization of inpatient care, and that support management systems necessary for inpatient care to be provided efficiently.

The Department maintains and reports computerized information on each admission and discharge in its inpatient facilities, derived from manual reports submitted by medical records staff at each facility (Monthly Facility Report). This reporting system has been streamlined to eliminate unnecessary or duplicative data and to standardize reporting categories. Data collected now include the DMH Area of responsibility for each admission and discharge, allowing direct measurement of inpatient utilization by each DMH Area in terms of admissions per capita and bed-day utilization. Data categories are compatible with the Client Registry allowing for eventual integration of the two systems.

An inpatient client tracking system, TRACE (Tracking Registration and Client Evaluation), was successfully implemented at Taunton State Hospital in FY'90 and will be installed in Westborough and Medfield State Hospitals during FY'91. This system maintains comprehensive patient data for all current and discharged patients, performs admission, discharge and transfer reporting, maintains a billing and accounts receivable subsystem, and has automated pharmacy inventory and prescription capabilities. The system has the potential to provide many clinical and administrative benefits and can accommodate additional software applications. Unfortunately, there is no funding available at this time to extend the system beyond the three hospitals where installation is already scheduled.

Resource Information: Management Control System

In order for resource data to provide useful information to support management decision-making, it must be properly linked to information about clients and services. The recent development of the Department's Management Control System (MCS) makes it possible to analyze resources as they relate to clients served and services provided. The MCS links the state accounting system (MMARS), the personnel database (PMIS), and the Department's Client Registry, allowing more thorough and routine analysis of services and expenditures.

The MCS was used to generate the FY'90 Resource Inventory in July, 1990. The Resource Inventory provides a programmatic analysis of Department spending, detailed by Area, for all appropriation accounts.

Office of Data Management

As DMH implements ambitious new automated systems to support billing, client tracking, and other functions, the need for coordination among information systems becomes increasingly apparent. The organization of the new Office of Data Management, funded in part through the federal

Mental Health Statistics Improvement Program (MHSIP), is designed to ensure that the DMH systems development takes place in the most coordinated and efficient manner. The office is responsible for establishing standard identifiers and coding schemes for the DMH systems. For example, adopting a standard client ID will allow the Department to track clients across different levels of the service system. In addition, the office is responsible for improving the integration of existing and planned DMH systems, so the same data is not repetitively entered into separate systems.

The long-range goal for DMH client systems is a comprehensive, fully integrated system with on-line access in all DMH Area offices, facilities, case management offices, and program sites. The system will track service involvement and service history for all DMH clients, automate the ISP for case managed clients, and capture detailed service events for DMH inpatients, such as medication orders, ancillary services, and episodes of seclusion and restraint. The focus will be on improving integration of existing systems that build on our progress so far.

Area Planning Process

In order to monitor and evaluate the performance of the mental health system, DMH has focused on a number of related activities, including quality assurance, licensing, and performance contracting. Each of these activities is a component of an Area Planning System that can be used to measure system progress on key priorities and goals.

The Department has initiated an Area-based planning process to link goals and objectives to performance monitoring activities (quality assurance, licensing and contracting) with a special focus on the unique needs and characteristics of Area consumers.

Area plans will merge relevant data on needs, services, and resources with feedback from other performance monitoring activities to create a blueprint to guide Area managers on an annual basis. An Area planning format has been designed, and a schedule determined; it is anticipated that all Areas will have plans completed for FY'92.

Purchase of Service Reforms

Many of the services DMH makes available to its clients are provided by (mostly) nonprofit vendors with whom the Department contracts. There were 1,075 contracts totaling \$199 million at beginning of FY'91. Budget cuts to contracted services since July, 1990 have significantly reduced

that number. As of March 1, 1991 there were approximately 1,025 contracts worth a total of \$196.5 million. It is anticipated that \$2 million in additional reductions will result from the furlough program and other cuts. Contracted services range from acute inpatient, community support clubhouse, day treatment, and residential services to home-based treatment, pharmacy services, crisis intervention, skills training, food service, pest extermination, consolidated laundry and medical laboratory services. Of the total, approximately \$190.5 million is spent on mental health services with the remainder spent on facility operations.

Since 1986, there has been growing concern about the accountability and stability of the Commonwealth's purchase of service system. As part of the state's agenda to reform this system, the Department has expanded its management focus from fiscal accounting measures to broader measures of programmatic performance. Ideally, contract performance will be measured through client outcomes of growth in functioning, employment and general well-being.

Performance-based contracting will enable the Department to evaluate effectively each program's performance against an established set of standards. Outcome will be used as a determinant in awarding future contracts. DMH is developing performance indicators for all service types and is incorporating these indicators into contracts as service types come up for bid on a newly established five year cycle. For FY'91, performance indicators were tested and incorporated into newly procured contracts for three service types: Staffed Apartment, Community Support Clubhouse and Supported Employment. Vocation Skills Building and Psychiatric Day Treatment are currently under review.

An additional goal in reforming the purchase of service system is the implementation of a market-based pricing system to remedy the current inequitable system which consistently underfunds contracts by simply rolling over historical expenditures. This new system would provide vendors with some stability, enabling them to plan more effectively to meet the needs of the Department's clients. An important component of the market-based price is an allowance for retention of revenues in excess of current expenses to address provider undercapitalization. In the current budget climate, however, the impact of this system would be an increase of 20 - 30% in prices and in a year of level-at-best funding would mean service cuts of 20 - 30%. This dilemma has not yet been resolved.

CHAPTER FIVE

STATEWIDE SERVICES

Although the bulk of mental health services are described, organized and provided through the adult or child and adolescent service systems, there are certain programs and/or services that are provided generically statewide. Of these shared services, some are provided through Area Offices and local service sites.

- Emergency Services
- Case Management Services
- Quality Assurance

Others are coordinated STATEWIDE

- Internal Affairs
- Human Rights
- Citizen Monitoring Program
- Forensic Mental Health Services
- Services to Special Populations who are Seriously Mentally Ill
and:
 - deaf or hard of hearing
 - elderly
 - homeless
 - multicultural
 - refugees and immigrants
 - medically involved
 - substance abusers
 - HIV+ or have AIDS

Emergency Services

Emergency services are a fundamental component of the mental health system. These services must be designed to ensure that adults, children and adolescents in psychiatric crisis are responded to quickly and appropriately. This means that the emergency service system must have the capacity to: provide evaluation and assessment by professional staff; go to the person in crisis when necessary rather than requiring that person to come to a specific site; and, respond to the specialized linguistic needs of the person in crisis (interpreter services and TTY access).

The emergency service system must be well integrated with the rest of the mental health system as well as with local community services, such as the police. Area residents, hospitals and the police should know how to

gain access to the DMH emergency service system. Therefore, each DMH Area must engage in public education to ensure this accessibility.

Emergency service staff should be sensitive to the needs of the individual in crisis in relation to involving members of their natural support system. Specifically, family members, friends or advocates should be encouraged and allowed to participate in helping stabilize the situation if the individual in crisis wishes them to be involved in that process.

Goal

The goals of the Emergency Services System are to assist individuals who are in psychiatric crisis to resume stable functioning and to prevent unnecessary hospitalization. The emergency service system is available 24 hours a day to help people through the crisis and then resume regular activities.

Eligibility

The emergency service system will provide services to any individual experiencing a mental health crisis. A mental health crisis may include one of the following situations:

- a person presents a serious risk of harm to self or others by virtue of mental illness;
- a person presents a clinical picture of acute mental illness or acute emotional disturbance;
- a person requests hospitalization or is referred for screening for hospitalization.

Description

The major functions of this service are:

- to stabilize persons in psychiatric crisis; to provide needed clinical intervention and treatment;
- to clearly determine when hospitalization is required and arrange for necessary admission or an appropriate alternative in an expedient manner;

- to assist primary consumers and members of their natural support system in resolving problems and stresses that may have contributed to the crisis; and
- to gain community support services which will help the primary consumer maintain an optimal level of functioning in the community following the crisis.

Emergency services are available 24 hours a day through each DMH Area with the following capabilities: on-duty or on-call board eligible or board certified psychiatrist, licensed to practice in the Commonwealth, with approved admission privileges for the appropriate DMH facility/facilities; an on-duty or on-call licensed mental health clinician experienced in the evaluation of children and adolescents; adult and pediatric medical evaluations; specialized assessment and crisis intervention for people who are hearing impaired, multicultural, or mentally retarded and for other populations with specialized needs as specified by the Department.

The two components of the emergency service system are crisis intervention and emergency shelter. Crisis intervention services include an initial screening, assessment, determination of need for hospitalization, crisis counseling, specializing, medical clearance, and referral for placement. Emergency shelter services provide crisis stabilization by assisting the individual in crisis in the least restrictive environment while trying to maintain linkage to his or her community support system. Emergency shelter may be provided in a variety of sites, including free standing emergency programs, general hospitals, respite care facilities, within the homes of trained and supervised families or at the emergency service site itself.

Office of Client Services and Emergency Management

In addition to the goals, eligibility and components of the Emergency Service System as described above, the Department also responds, through its Office of Client Services and Emergency Management, to natural and man-made disasters requiring intervention and assistance to persons in psychiatric crisis, (victims and first-responders), due to such disasters. The Department coordinates its efforts with both the Federal Emergency Management Agency (FEMA) and the Massachusetts Civil Defense Agency (MCDA) to ensure that regular preparedness training is carried out and that, in the event of a disaster, resources are appropriately located and directed.

Recent examples of this service are the Department's response to a catastrophic fire in Revere, MA in December, 1990, and the Department's preparations for dealing with returning civilian repatriates from Operation Desert Storm.

As the Revere fire was declared a "limited state disaster" DMH assumed responsibility for providing crisis counseling to victims of the fire that included 134 displaced persons, 80% of whom were Asian or Central American. Separate debriefing sessions for victims and other community members were held (arson was suspected in this fire), and specialized outreach, counseling and, where needed, psychiatric pre-screening and hospitalization were provided. Emergency funds were made available through DMH to hire three part-time counselors (English, Khmer and Hispanic) who worked out of a local counseling center. Victims were helped to gain access to other needed services as well.

Whereas the federal Veteran's Administration is responsible for providing mental health services to service men and women and their families, DMH is deemed responsible for ensuring the provision of mental health services, if necessary, to returning civilian repatriates. In addition to FEMA and MCDA, the Department works with the (federal) Department of Health and Human Services, state and private agencies, private industry and voluntary agencies to coordinate activities and planning. The Office of Client Services and Crisis Management, in conjunction with the Trauma Clinic at Massachusetts Mental Health Center in Boston, began a series of meetings in February, 1991, to discuss strategies for mental health responses to Operation Desert Storm.

At a time when DMH is trying to focus on the needs of its priority clients in a climate of diminishing resources, there are increased demands on the entire system as a result of stresses on families and individuals because of the war and the uncertainty brought about by rising unemployment and the state's fiscal situation. DMH will continue to provide emergency services to anyone in crisis and then direct clients to appropriate facilities and programs for follow-up care in keeping with its mission and its treatment policy.

Case Management Services

Case managers, accessible through local case management offices, assist priority DMH primary consumers, and families in the case of children and adolescents, in establishing goals, gaining access to services, and developing the skills and/or supports necessary to achieve those goals. They assist adult primary consumers to take responsibility for their lives to the fullest extent of their capabilities. The emphasis in the case manager/primary consumer relationship should be on partnership. In essence, it is a joint effort to help individuals make use of formal and informal systems that will enable them to achieve their goals. Primary consumers should expect that the case manager will support their efforts, even if those involve some risk of failure. Case managers must support primary consumers in making informed choices and exercising control over decisions about their lives. Case managers must not reinforce learned helplessness, but rather appreciate and respect each consumer's dignity and right to choice.

Goal

Case managers assist adults and children and adolescents and their families to gain access to services and make choices. The development of an Individual Service Plan (ISP) is the mechanism to facilitate access to services. The ISP is an opportunity for primary consumers to establish goals for themselves and to identify those services that will help them to achieve these goals. Case managers support individual consumers as they develop a greater sense of self-esteem and recognition of their own power.

Eligibility

Case management services are available to adult DMH priority consumers, specifically those individuals with a serious, long-term mental illness who are unable to independently meet life support needs for food, shelter, clothing and health care. Case management services are also available to children and adolescents under the age of 19 who are seriously mentally ill or severely emotionally disturbed who are currently receiving or who have been referred for hospitalization, residential or day treatment services, or who are determined by DMH to be at risk of hospitalization. It should be noted that for children and adolescents, unless family involvement is contraindicated, both the child and his/her family are considered to be the consumer.

Description

The following functions are performed by case management staff:

- determines eligibility;
- facilitates access to non-DMH services such as special education, social services, Medicaid, vocational programs and housing;
- assesses individual consumer needs, in conjunction with the consumer, families and other caregivers where appropriate, and the consumer's primary clinician;
- assists the consumer in developing an ISP that identifies goals set by the consumer for him/herself and those services which the consumer believes will help achieve those goals;
- connects primary consumers to appropriate services;
- monitors the quality and effectiveness of services to individual consumers allowing them to assess whether the services meet their individual needs; to amend the ISP as needs change;
- supports families and other formal and informal care givers; and
- advocates on behalf of clients to ensure equity, due process and access to applicable rights and privileges.

Quality Assurance

To ensure the development and implementation of effective services throughout the Department, the Office of Quality Assurance develops appropriate mechanisms for measuring the quality of services provided to consumers. The focus of quality assurance is client-centered outcomes, rather than administrative process. The Office of Quality Assurance is a unit within the office of the Deputy Commissioner for Mental Health Services.

Quality Assurance includes the monitoring and evaluation of services provided or purchased by the Department, overseeing accreditation of facilities by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and overseeing certification by the Health Care Financing Administration (HCFA), and performance based contracting.

The primary focus of the Office of Quality Assurance this year will be to assist the hospitals and community mental health centers in developing policies and procedures required for JCAHO and HCFA accreditation and certification.

In addition, a community-based quality assurance model has been defined that consists of three integrated components:

- provider self-monitoring - an ongoing, internal review process, designed to track critical aspects of service delivery on a proactive basis
- program evaluation - a point in time assessment, designed to evaluate the process and structure of a program in relation to goals and outcomes
- performance-based contracting - an outcome monitoring system, designed to track and compare provider performance in relation to quality of care objectives

A working group is actively developing Standards, a Program Evaluation instrument and a Training Manual which will enable the Office of Quality Assurance to pilot the entire system.

Internal Affairs

The Department of Mental Health is committed to ensuring that any complaint alleging actions or conditions which are dangerous, illegal or inhumane are investigated. There are two mechanisms in place to ensure that these complaints are reviewed appropriately.

The Office of Internal Affairs within the Commissioner's Office oversees the state-wide implementation of DMH regulations 104 CMR 24.00. These regulations provide for the investigation and subsequent appeal rights for any complaint filed by an advocate or consumer regarding dangerous, illegal or inhumane conditions within DMH programs and facilities. Each

Area and facility has investigators who report to the Director of Internal Affairs at Central Office.

The second mechanism is the Disabled Persons Protection Commission (DPPC). This Commission, established by the Legislature in 1986, is a quasi-independent agency in the Executive Office of Health and Human Services responsible for investigation of cases of alleged abuse or neglect within the human service agencies or by primary caretakers in the community. DMH works collaboratively with the DPPC to conduct these investigations and to provide protective services for DMH eligible service recipients when necessary.

Human Rights

The Department of Mental Health subscribes to the principle that every recipient of mental health services is to be provided the least intrusive, least restrictive services appropriate to his or her individual needs and designed to maximize his or her potential to live independently. Services are to be provided in a manner which respects each client's dignity and affords him or her the opportunity to fully exercise his or her legal rights.

To this end, DMH has a system of human rights officers and human rights committees in all of its facilities and programs to ensure that the human rights of clients are protected. Overall coordination of issues and policies related to human rights and supervision of state hospital human rights officers and committees is provided by the Special Assistant for Human Rights in the office of the Commissioner.

Human rights officers assist clients in advocating for their rights, train staff and clients on human rights issues, assist and monitor the formal complaint process and monitor program policies and regulations for compliance with human rights goals.

Human rights committees monitor the activities of each DMH program with regard to the human and civil rights of the clients served by the program. The committee monitors seclusion and restraint data, visits each program at least once a year and provides advice on human rights issues.

A statewide Human Rights Advisory Committee advises the Commissioner on policies and issues relating to human rights.

Citizen Monitoring Program

The Department has a unique program to review and monitor the quality of life at its inpatient facilities. The Citizen Monitoring Program grew out of a cooperative effort between the Western Massachusetts Alliance for Mentally Ill Citizens and the Department, in 1983, to establish a program enabling family members of patients to monitor services at Northampton State Hospital. Family members at Medfield State Hospital began a similar program. This program was later expanded under the auspices of the Statewide Alliance group to all the state hospitals and community mental health centers with inpatient facilities.

Volunteer citizen monitors receive formal training and make unscheduled site visits at least once a month to their assigned facility. The program is centrally coordinated by the Department and the Alliance for the Mentally Ill. Monitors' reports address facility and management issues as well as clinical and programmatic aspects of hospital care. In addition to effecting real changes in the care and treatment of patients, the program has been successful in breaking down attitudinal barriers between families and hospital staff.

Forensic Mental Health

Mission

The Department of Mental Health has a long tradition of providing services to adults and adolescents involved with the criminal justice system. In 1985, after the Court Clinic Services Committee, created by the Legislature, reviewed the Department's court-based service system, DMH created the Division of Forensic Mental Health (DFMH).

Responding to the concerns of the courts and county correctional officials, the Division has worked to develop a comprehensive, efficient, centralized system for delivering forensic mental health services across the Commonwealth to ensure that court-involved persons with serious or long-term mental illness are offered the mental health services they need. DFMH also ensures that those without serious mental illness are responded to appropriately by the courts without putting an inappropriate burden on the mental health system.

Responsibilities

- provides clinical and forensic evaluation services at courts;
- assists the Department to assess and care for seriously mentally ill or severely emotionally disturbed persons who become involved with the criminal justice system;
- develops mental health services in county correctional facilities;
- provides consistent central standards for training, qualification, and practice for forensic mental health evaluations conducted per court order in hospitals and other settings not under the direct supervision of the Division;
- maintains operational responsibility for the Taunton Secure Care Program, a 25 bed forensic evaluation and treatment program for court-referred mentally ill men and women; and
- maintains operational responsibility for the Treatment Center at the Massachusetts Correctional Institution at Bridgewater State Hospital. This is a 250 bed facility operated under the provisions of Massachusetts General Laws and two federal

consent decrees. It provides housing, security, and clinical care for men convicted of violent sexual crimes who have been adjudicated as "sexually dangerous" by the Superior Court and committed to the Treatment Center for an indefinite "one day to life" commitment.

Services

The Division of Forensic Mental Health currently provides services at 62 of the 69 District Courts, including District Courts sitting in juvenile session; at the Boston Municipal Court; at the Juvenile Court Departments of Boston, Springfield and Bristol County; and at 13 Superior Courts. Services provided at these courts include:

- court-ordered evaluations, both statutorily and non-statutorily specified;
- consultation to judges, probation staff and court officers; and
- referrals to mental health facilities and service providers for court-involved persons in need of mental health and other services.

The Division also provides services in nine of the fourteen county correctional facilities. Services were introduced in one additional facility this year (Plymouth Jail) and expanded in two others (Charles Street Jail and Dedham Jail). Two new county facilities containing specialized mental health units are scheduled to open during FY'91 (Essex and Suffolk). The introduction or expansion of forensic mental health services into county facilities has been effective in significantly reducing referrals to Bridgewater State Hospital for forensic evaluations.

In FY'89, the Division of Forensic Mental Health spent approximately \$7.6 million to provide services at 90% of the District, Juvenile and Superior Courts of the Commonwealth and in county correctional facilities in nine counties. After spending cuts, the Division's projected budget for FY'91 is about \$5.7 million.

Specialized Service Populations

The Department of Mental Health recognizes that there are a number of seriously mentally ill persons who have specialized needs and has made a commitment to address the needs of these populations. The Department defines its special populations as groups of seriously mentally ill people that share these common characteristics:

- they experience significant barriers to gaining access to traditional mental health services;
- they are in need of some specialized services;
- they are traditionally underserved or inappropriately served; and
- they have experienced forced migration with a history of extreme and/or multiple trauma or have a secondary disability.

Members of these groups must also meet the DMH eligibility requirements for long term or serious mental illness or severe emotional disturbance. DMH includes in these populations the following individuals: persons who are deaf or hard of hearing; cultural and linguistic minorities; refugees and immigrants; the elderly; persons who are homeless; persons who have a substance abuse problem; and, persons with AIDS or HIV +.

Services for these populations require a balance between accessible mainstream and specialized service models. Therefore, the focus of program development for these populations has been directed to three priority issues:

- improving access to existing mental health services;
- providing technical assistance, training and consultation to mental health staff on the needs of these groups; and
- developing specialized services where appropriate and practical.

Improving Access to Existing Mental Health Services

Cultural and Linguistic Minorities

Persons for whom spoken English is not their primary language must have access to culturally and linguistically appropriate mental health services. Due to the limited availability of bilingual/bicultural staff, it may at times be necessary to provide interpreter services to ensure appropriate access. The Department continues to provide funds to hire interpreters for emergency situations, family meetings and case conferences. Unfortunately, sufficient funding is not available to provide long-term interpreter services. Utilization of interpreter services has risen steadily each year corresponding to the increase in need. In FY'91, DMH has provided language interpreter services for the deaf and hard of hearing and for the following linguistic groups: Albanian, Cambodian, Haitian, Iranian, Laotian, Portuguese, Russian, Spanish and Vietnamese. The Department is committed to the continued existence of the interpreter funds, and hopes to expand the availability of this service when the state's fiscal crisis has passed. Telecommunication devices for the Deaf (TTYs) are located in the DMH Area offices and in the Department's Central Office.

A critical way of improving access to existing mental health services is to increase the availability of bilingual/bicultural staff. The Department considers this a priority and will continue to work to attract additional bilingual/bicultural staff into the mental health system.

The Homeless

Homelessness in Massachusetts affects an estimated 6,500 people each night, with an estimated 3,000 of those persons being members of 1,000 homeless families. At any one time, it is estimated that 21% of 3,000 single adult shelter users have a chronic mental illness (9% mentally ill, 12% mentally ill with accompanying severe substance abuse). Improving access to the mental health system for persons who are homeless is addressed through collaborative relationships between the shelters and the mental health system. Better integration of the Homeless Services Unit with the crisis intervention services at the community mental health centers in Boston was accomplished through the creation of a Metro-Boston Emergency Services Coordinating Committee which continues to meet twice monthly. In addition:

- DMH policy requires each Area to maintain a Shelter Services Agreement with each shelter in its Area describing how clinical, case management, crisis, and educational services will be provided to that shelter.

- DMH case management policy gives priority to individuals who are homeless and have long-term or serious mental illness.
- DMH provides psychiatric nurses at non-DMH Boston shelters to treat health problems and manage medication compliance.
- DMH funds a Homeless Outreach Team that identifies people in need of services and then works with those persons to connect them with the shelters.
- DMH funds four shelters statewide for mentally ill homeless people. These shelters receive referrals from non-DMH shelters and are oriented toward stabilizing clients, rather than as transitional facilities. Each shelter is affiliated with a community mental health center and has a clinically trained staff.
- DMH funds an intensive care detoxification center for substance abusing homeless mentally ill people.
- A comprehensive program funded through the Homeless Services Block Grant (NIMH) enables DMH to provide 19.5 (FTE) master's level clinicians (Shelter Specialists) to individual and family shelter sites across the state. They provide direct care to individuals as well as provide referrals to job training, literacy education, community mental health centers, substance abuse treatment and programs that provide benefits and entitlements. The Department is proposing to use 2.5 (FTE) of these positions to hire Housing Service Advocates. These advocates would work to secure existing housing in designated "high need" areas, provide technical assistance to clients identified and referred by the Shelter Specialists, document gaps in housing and consult to the 17 Shelter Specialists as needed.
- DMH applied for a grant that was approved but not funded to hire and train formerly homeless people to function as case managers for the homeless mentally ill in shelters. This approach, it is felt, would allow for more consistent and acceptable outreach among mentally ill residents of the shelters.
- Under a McKinney/HUD grant, DMH will provide 120 units of housing in Metro-Boston to demonstrate the effects of two housing models on homeless mentally ill adults and determine the relationship between client characteristics, client preferences, clinician judgment and client outcomes in these residences.

Providing Technical Assistance, Consultation and Training to Mental Health Staff

Mental health staff often do not have the specialized training or expertise to provide services appropriate to special populations. Therefore, the Department has initiated a variety of strategies which will provide

opportunities for staff to enhance their knowledge so they can plan and provide more appropriate services.

The Office of Multi-Cultural Services (OMCS) and the Refugee Assistance Program (RAP) within DMH are the focal points for the Department's efforts to provide services to **multicultural groups**. RAP and OMCS staff participate actively in various community groups to assist in developing relationships between DMH and the multicultural communities. In addition, these DMH offices provide training and technical assistance to mental health staff on planning for services to meet specialized needs, to deal with cross cultural issues, to provide case specific consultation and to assist Areas and hospitals in developing culturally and linguistically appropriate services for seriously mentally ill persons.

The Coordinator of Deaf and Hard of Hearing Services works with mental health staff, as well as other state agencies, to assist the Department in meeting the mental health needs of individuals who are **deaf or hard of hearing** as well as seriously mentally ill. In-service training has been made available for emergency service staff as well as other clinical staff throughout the state. The Coordinator also assists DMH staff in planning appropriate services for individual clients. Specialized services for the deaf mentally ill include: a 10 bed inpatient unit at Westborough State Hospital, specialized outpatient clinic services in 6 Areas, 3 community residences serving 13 clients, one community support clubhouse and one supported employment program.

The Department of Mental Health and the Department of Public Health have participated jointly in a number of initiatives focused on service delivery to persons with mental illness and **substance abuse problems**. These initiatives will continue during the next year. Cross agency trainings regarding program development to meet the specialized needs of these individuals has been conducted and additional trainings and conferences are scheduled for 1991. The Department will also be continuing its research project to evaluate the effectiveness of adding drug abuse and alcohol treatment services to standard psychiatric treatment of seriously long-term mentally ill state hospital patients with co-occurring alcohol/drug abuse disorders. The outcomes from this project include training manuals, refinement of assessment tools, and will provide information which can be utilized by practitioners around the country. In addition, a new DMH dual diagnosis workgroup has formed to address the needs of this client group. The workgroup will analyze client data, survey and track existing programs, coordinate current and future research projects, and make recommendations regarding service delivery. Initially comprised of professionals from throughout the DMH system, the group

plans to eventually expand its membership to include other state agencies, the Alliance for the Mentally Ill and consumers.

The Department continues to provide mental health care for its priority clients who have **AIDS or HIV +**. Among the Massachusetts human service agencies, the Department of Public Health has the primary responsibility for planning a service system for people with AIDS. However, DMH has taken steps to address the policy and programmatic issues related to AIDS within the DMH population, including extensive and ongoing training for staff on AIDS and AIDS education, and adopting universal precautions in all inpatient facilities. In addition, the Department received research approval (but no funding) from the National Institute of Mental Health to study AIDS prevalence among psychiatric inpatient populations. The Department is currently deciding whether or not to reapply for funding. Finally, the Department's new AIDS policy, which incorporates the Center for Disease Control's recommendations on Azidothymidine (AZT) prophylactic treatment, became operational on May 1, 1991.

Budget cutbacks have significantly impacted the Department's capacity in the area of **geriatric services**. However, a new 20-bed inpatient unit providing acute stabilization and evaluation services was opened this year at Westborough State Hospital. This unit provides an opportunity for geriatric clients to receive an appropriate evaluation from staff trained in psychogeriatric services. An innovative therapeutic residence for 8 elders with serious or long-term mental illness opened recently in Shrewsbury. It was developed with Chapter 689 (housing) funds and is operated by a local private vendor under contract to DMH. At least several of the residents were formerly long-stay hospital patients. In addition, DMH is compiling a resource guide to identify and describe services for geriatric consumers in each Area. It is expected that the guide will assist staff in searching for appropriate programs for elders and assist DMH in planning efforts by identifying gaps in the existing service system. A conference is planned for the spring of 1991 to address the training needs of case managers and other DMH staff who work with geriatric clients in the community.

Development of Specialized Services Where Appropriate and Practical

The budget crisis has seriously impacted the Department's capacity to develop many new specialized services. However, through some consolidation as well as work with private agencies some of the needs have been addressed.

One of the exciting opportunities this year was the opening of the Farren Care Center, developed specifically to serve persons who are seriously mentally ill and medically involved and who had been residing on DMH inpatient units. Farren Care Center provides specialized care in the community for these individuals and will ultimately be serving 77 former DMH inpatients.

In addition, DMH funds totally or in part:

- Metropolitan Indochinese Child/Adolescent Services (Boston): outpatient mental health services, hospital diversion and inpatient support to 120 10-21 year old Khmer, Vietnamese and Lao clients.
- The Indochinese Psychiatry Clinic (Boston) : outpatient mental health services to 145 clients.
- Haitian Mental Health Unit (Cambridge): outpatient mental health services and inpatient support to 230 clients.
- St. Ann's Home (Lowell): outpatient mental health services to 18 Cambodian youth.
- South Cove Community Health Center (Boston): outpatient mental health services for the Chinese community.
- Inquilinos Boricuas en Accion (Boston); Gandara Center (Springfield); Casa Primavera (Cambridge); and L'Allianza (Boston) provide outpatient mental health services, support services and a clubhouse for Latino youth, families and adults.

Specialized services that need continued advocacy and planning during this next year include services for young adults turning 22 years of age who are deaf and mentally ill. The Department is collaborating with other state agencies to plan a program for these individuals as well as for the service and program needs of deaf and mentally ill children and adolescents. Increased bilingual/bicultural capacity in emergency, day and inpatient services is also a priority. Some areas of the state also need additional bilingual/bicultural case managers to serve specific populations in those areas. During this next year the Department will also be assessing its existing capacity to provide specialized services to geriatric clients and identifying specific areas that need further development. Planning efforts focused on increased collaboration at the local level between the geriatric services network and the DMH system will be emphasized.

CHAPTER SIX

SERVICE SYSTEM MODELS

This section of the Comprehensive Mental Health Service Plan describes two complete mental health service systems, or models, one for adults and one for children and adolescents. The models represent the ideal services the Department wants to provide for each population subset. Each component of the models contains a programmatic description as well as prevalence estimates and a quantitative "model capacity."

Prevalence estimates are used to assess the relative levels of need for mental health services among Areas and, more specifically, the numbers of clients who will meet the eligibility guidelines for priority clients in each Area. Model capacity represents the quantity of service that DMH estimates is needed to adequately serve that population.

Subcommittees formed as part of the P.L. 99-660 planning process developed both the adult and child/adolescent models and included a broad constituency of consumers, family members, advocates, professionals and DMH staff. Each model attempts to build on a base of currently available services and moves toward the development of a comprehensive system that ensures the provision of services that consumers want and need. In the process of refining the proposals, each subcommittee received substantial feedback from a wide audience of interested persons who participated actively to ensure that the final products were reflective of the needs of a broad spectrum of users of mental health services.

Overview of Service Network

The Department of Mental Health is organized into nine service delivery Areas which now oversee and coordinate an integrated system of mental health care including inpatient, emergency, case management, residential and outpatient services, as well as all contracting, monitoring, fiscal and personnel services necessary to support Area clients and programming.

Seven hospitals, the Gaebler Children's Center, the Bridgewater Treatment Center and eight community mental health centers with inpatient units provide acute, transitional and specialty inpatient care. Each facility is managed by its own executive officer with overall supervision provided by the Area Director (with the exceptions of Bridgewater Treatment Center and Gaebler which are under the supervision of the Division of Forensic Mental Health and the Assistant Commissioner for Child and Adolescent Services, respectively). Other services, as described above, are provided through a network of DMH operated facilities and private, vendor operated programs.

Adult Service System Model

Background

During this past year the Department of Mental Health has directed significant effort to the review and revision of the adult mental health system model. The proposed model outlined in the Comprehensive Mental Health Service Plan submitted in September, 1989, has been reviewed by representatives of advocacy groups, consumers, and other state agencies, as well as by both community and inpatient DMH staff. The input from these individuals who served on the Adult Subcommittee of the P.L. 99-660 Planning Committee was invaluable and the resulting service system model reflects the Department's continued commitment to serving persons with serious or long-term mental illness as a priority population. The revised model described in this section maintains a focus on the development of services that meet the medical/clinical needs and the support/rehabilitation needs of these DMH priority consumers. This model also reflects the commitment to providing services which are accessible, respect the legal and human rights of consumers and are appropriate and responsive to the needs of persons from diverse cultural and linguistic groups. A separate section on statewide services addresses the needs of many of these special populations.

The adult service system model has been written with language that strives to emphasize human dignity and consumer empowerment. Members of the Adult Subcommittee wanted to ensure that the description of the DMH service system is reflective of these basic values. For many of the components, specific references are made to the role of primary consumers in the development and/or evaluation of that service. However, descriptive language alone cannot ensure a service system which is respectful of human dignity. Therefore, the Department will be seeking a variety of strategies, through staff training, evaluation and consumer involvement to reinforce these values.

Rehabilitation philosophy and principles have been infused into the adult service system model. Through supported housing, supported employment and other community support services, as well as in the inpatient programs, rehabilitation has been emphasized.

Adult Prevalence and Capacity Measures

Over the summer of 1990 a Task Force, chaired by the Assistant Commissioner for Community Programs, considered alternative procedures for measuring mental health needs in DMH Areas. The Task Force reviewed research findings and made recommendations for the final estimation procedures. The Task Force adopted the research findings of Dr. Philip Leaf (then of Yale University) that the prevalence rate of adults meeting DMH eligibility criteria is .98%. This translates to 44,207 adults with long-term or serious mental illness.

The Task force also adopted the research findings of Dr. James Ciarlo of the University of Denver that the rate of occurrence of long-term or serious mental illness differs in each catchment area based on demographic characteristics. Dr. Ciarlo has developed prediction models which allow planners to estimate how many individuals are in each area using census data on poverty levels and family stability. These models were used to estimate how many of the 44,207 individuals are in each DMH Area.

Finally, the Task Force considered how many of the 44,207 adults should be considered in the "planning population" of the Department. Of the total number of seriously mentally ill people, not all will seek services from DMH. Some will be served in the private sector and some in the non-mental health service sector. In addition, research findings on help-seeking and treated prevalence indicate that many, if not most, individuals with a diagnosable mental illness will not seek help. After consideration of these research findings, the Task Force agreed to use a factor of 50% in determining the DMH "planning population" within the overall number of potential clients. This means that there are 22,106 adults in the Commonwealth for whom the Department must be prepared to provide services. The results of applying the procedure to the Massachusetts DMH Areas are shown in the table on the following page:

Adult Prevalence Estimates

	A Diagnosable Mental Disorders 15.22 %	B MI & Severely Disabled 0.98 %	C DMH Planning Population 0.50 %
Western Mass.	96,553	6,116	3,058
Central Mass.	79,132	4,894	2,447
Merrimack Valley	54,739	3,576	1,788
North Shore	70,341	4,429	2,215
Metro West	65,069	3,973	1,987
Metro South	63,575	4,071	2,036
South West	61,261	4,013	2,007
South Shore	69,059	4,190	2,095
Boston	126,878	8,945	4,473
Adult Totals	686,608	44,207	22,106

Column A: a diagnosable mental disorder with symptoms occurring in a twelve month period including schizophrenia, major affective disorders, anxiety disorders, dysthymia and phobic disorders. Excludes substance abuse, retardation, and organic disorders

Column B: severely disabled; unable to provide for basic self care

Column C: planning population; the Department's highest priority client group

The group called the Planning Population is the basis for estimating capacities for services to priority clients such as case management, residential and long term clinical treatment. However, emergency services and diagnostic and evaluation services must be available for all people in psychiatric crisis who request help from the Department. Therefore, it is important to know the total number of people in the community with mental health problems who may need access to these services. The chart on the following page describes statewide service targets/capacities. The numbers have not yet been converted to reflect adjusted distribution by new Areas.

Statewide Service Targets
Adults Services

Service	Category	Measure	Current* Capacity	Model** Capacity
Emergency		Programs	27	27
Case Management		Clients	7,649	22,106
Outpatient		Clients	77,000	77,750
Day Treatment		Programs	22	25
Clubhouse		Programs	15	44
Support Programs		Programs	22	45
Supported Employ		Programs	21	27
Residential		Beds	3,249	9,050
Family Support		Programs	9	27
Inpatient, acute***		Beds	439	****
Inpatient, other		Beds	1,858	****

* These are current capacities as of March, 1991 and reflect budget cuts taken since July, 1990.

** Model capacities may be refined to reflect Area reorganization.

*** This represents square foot capacity, not census.

**** These numbers will be determined based on the recommendations of the Governor's Special Commission on Facility Consolidation.

Adult Model Components

The model service system outlined in this section includes *emergency, case management, skill development and employment, residential, clinical, and support services*, as well as a description of *inpatient services*. However, emergency and case management, although integral parts of the adult service system, are discussed in the separate section on statewide services because they include services to children and adolescents as well as adults. Together these components provide a comprehensive array of services from which priority primary consumers may choose those which best address their needs.

Skill Development and Employment Services

DMH primary consumers should have available a variety of programs designed to enhance their skills in community living, education, work and the development of social networks. These services should be developed to maximize the consumer's choice and provide the skill training and support necessary to achieve selected goals. In addition, these services focus on enhancing the individual's decision-making capabilities. Skill development and employment services should have a clear rehabilitation focus in philosophy and practice. Through these services primary consumers should be encouraged to set goals for themselves in the areas of education and work and to actively pursue those goals. The consumer's choice should be the driving force in the determination of which service he or she feels would be most helpful.

Goal

The goals for skill development and employment programs include providing opportunities for people with psychiatric disabilities to come together for mutual support, to assist individuals in finding meaningful employment, and to assist in the development of social networks. To accomplish these goals, this model will include an array of program options in each DMH Area to allow primary consumers a choice in services.

Eligibility

DMH priority consumers are eligible for skill development and employment programs.

Description

The adult model includes three service types in this category: skills training programs; community support clubhouses; and, supported employment.

Skills training programs offer an array of approaches to assist primary consumers in acquiring basic vocational and educational skills in the programs of their choice in the community. Each primary consumer will have a specific rehabilitation goal-oriented plan with educational and/or vocational goals. The components of a skills training program may include: supported businesses; supported education; skills training classes; career planning classes; GED classes; individual tutoring; and vocational skills development.

Community Support Clubhouses provide support services through a comprehensive self-help clubhouse. Staff and clubhouse members (i.e., primary consumers) work as teams to perform the tasks necessary for the operation of the clubhouse. The components of a community support clubhouse include: work ordered day program; transitional employment; active outreach; and evening and weekend social programs. The clubhouse model may also include supported education, case management and advocacy components. The primary emphasis is on maximizing member participation in program planning, operation and evaluation. The clubhouse model provides flexibility and choice for priority clients and presents opportunities for consumer run programs. DMH has developed fifteen clubhouse programs and ten more are in the process of being developed.

Supported Employment provides a real job in the community paying a competitive wage with staff support on the job. The jobs range from part-time to full-time and staff support is provided from three months to several years. The components of a supported employment program include assessment of skills necessary for available jobs, assistance for consumers with placement in a job of their choice, supervision on- and off-site by a staff member, supportive counseling and follow-up when appropriate. The services are tailored to individual need including support, skills training and assistance in accessing other services or benefits on

the job. These programs have the flexibility to locate staff where they are needed and relocate as the needs of the consumers change.

Residential Services

The availability of a range of residential services which provide primary consumers the support needed to stay out of the hospital is fundamental to the adult services model. Within the continuum of residential services primary consumers should have a choice between programs which provide a high level of structure and staff support and programs which provide a few hours of staff support each week. Consumers should expect to receive assistance as needed in developing skills in: shopping, meal preparation and housekeeping. In addition, staff support may be provided in finding a roommate, negotiating a lease, obtaining rental assistance or communicating with the landlord.

One of the most important aspects of residential services is helping the consumer to maintain a stable living environment. With this in mind, the Department has made a commitment to increase the availability of programs based on the supported housing model. This program model is based on the principle that a residence is the consumer's home and that he or she should not have to leave that location simply because the level of need for staff support has changed. Instead, the available staff support changes as the consumer's needs change, but the individual remains in his or her home.

Other aspects of residential service options on which the Department will be focusing attention are consumer-operated or consumer-staffed programs. Consumers involved in the planning process during this past year have indicated a great interest in further developing these alternatives. The peer support provided in these programs is extremely beneficial for some consumers.

Over the next year, the Department will be refining the residential service model so that staffing levels, licensing requirements, and program descriptions are consistent.

Goal

Residential programs assist consumers in maintaining a stable living environment. All residential programs provide rehabilitation skills

training in the areas of money management and budgeting, food preparation and shopping, and basic maintenance and housekeeping.

Eligibility

DMH priority consumers are eligible for residential services. Homeless persons with a serious, long-term mental illness and persons recently discharged from state hospitals are the highest priority for DMH residential services.

Description

The adult model has five levels of residential services available to primary consumers: specialized residence; high intensity residence; moderate intensity residence; low intensity residence; and, flexible support residence.

Specialized residences provide intensive support and/or skills training for residents with specialized service needs. Staff are present twenty-four hours per day. These programs are specially designed to meet the needs of the following individuals: medically involved consumers; geriatric consumers requiring intensive support; consumers who experience severe behavioral symptoms of mental illness; and consumers who are hearing impaired and require a specialized signing environment.

High intensity residential programs focus on functional education to develop daily living skills such as bathing, cleaning, and cooking. These programs are designed to provide a high level of staff involvement for those residents needing substantial skill training and support in a structured environment. Components of this service include: intensive skills training or assistance in personal care and hygiene; intensive skills training and assistance in meal preparation; intensive skills training and assistance in basic housekeeping; assistance with managing symptoms of mental illness which interfere with daily functioning; assistance in developing positive social relationships; and in-home psychiatric crisis services.

Moderate intensity residential programs are designed for residents who require structure or verbal support from staff to accomplish daily living skills, but do not require one-to-one attention to accomplish those tasks. Components of this program include those identified in the high intensity residence but with less direct staff intervention and assistance.

Low intensity residential programs are designed for residents who are capable of handling non-crisis issues for a day or two until a scheduled staff visit. Staff visits include support and assistance, skills training, and consultation with individuals who are part of the resident's natural support network. Staff are available no less than 15 hours per week per program site. Consumers participating in this program should expect to receive assistance in refining living skills including shopping, budgeting, meal preparation and housekeeping; support and assistance in maintaining a positive relationship with landlord or others in the resident's natural support network; assistance in accessing other needed services or entitlements.

Flexible support residences provide the opportunity to address all levels of residential services in one contract. The programs focus on addressing service needs of consumers at more than one site, and at the level of service required by the consumers. The purpose of this model is to enable residents to live at the same site with the level of staff support changing as their needs change. Components of this model include: services tailored to individual need, including support, skills training and assistance in accessing other services; flexibility to locate staff where they are needed and to relocate them as the consumer's needs change; and capacity to transition residents to greater levels of independence in their current homes.

Inpatient Services

Goal

The availability of high quality psychiatric inpatient services that provide short-term acute, extended care, and specialty care is fundamental to a comprehensive mental health service delivery system. The Department's goal is to provide effective and appropriate inpatient services for persons who experience acute episodes of their illness, or have demonstrated a danger to themselves or others due to mental illness, and then to assist the individual to return to the community. Department inpatient services for adults are provided in seven state hospitals and eight community mental health centers.

Eligibility

Those people who are experiencing an acute episode of their mental illness, who meet the commitment criteria outlined in M.G.L. Chapter 123, i.e. individuals who present a substantial risk of physical harm to

themselves or others, are admitted to DMH inpatient units. In addition to those individuals who meet Chapter 123 criteria, individuals are also admitted who are committed under court order for evaluation of criminal responsibility and/or competency to stand trial.

Description

To provide persons on the inpatient units with the most effective services, a comprehensive treatment plan is developed based on a complete diagnostic evaluation integrating Medicine, Psychiatry, Psychology, Social Work, Nursing and Rehabilitation. The goal is to provide a short inpatient stay to stabilize the individual and assist in planning rehabilitation, support and vocational services in the community that meet his or her needs. A major function of the inpatient stay is to provide psychiatric monitoring and evaluation of the individual's medication and symptoms. During the time a person is on an inpatient unit he or she will have access to rehabilitation services which will assist in developing those skills helpful to transition back to the community. An important component of an inpatient stay is the discharge planning to link the individual to the appropriate services in the community.

Acute/Admissions Units

These units are designed and staffed to provide treatment to individuals in an acute phase of a serious mental illness. Length of stay is expected to be 90 days or less. The principal clinical interventions include crisis management and stabilization, medication adjustment, individual and group therapy and rehabilitation services.

Extended Care Units

The extended care units are designed to provide hospital care to individuals who require a hospital stay of more than 90 days or who require less intensive but longer term therapeutic intervention. Treatment is focused on helping the individual cope with his/her mental illness and rehabilitation programs, develop skills in personal hygiene, social interaction, leisure time and vocational readiness. The goal for these units is to assist the patient in reaching a level of functioning that will allow him/her to return to a more independent setting in the community. Many of the patients from these units will participate in transitional on-campus housing programs or in DMH funded residential services.

Intensive

The DMH system also has the capacity to provide secure intensive care for patients whose illness manifests itself in unpredictable or violent behavior. Staff in these units are specially trained to prevent or manage

instances of violence and respond to the needs of patients with histories of serious assaultive behavior.

Specialized Inpatient Units

The Department also provides specialized services for seriously mentally ill persons with unique needs for inpatient care and treatment. Included in these specialized services are units for persons who are: deaf; mentally retarded; medically involved; elderly; and, persons who have substance abuse problems.

Clinical Services

In addition to emergency and inpatient services, other clinical services to DMH consumers include outpatient services, psychiatric day treatment and forensic evaluations. Through these services primary consumers may receive evaluation/assessments, short-term psychotherapy, long-term psychiatric care, medication monitoring, day treatment and forensic evaluations. Forensic services are discussed more fully in the separate section on statewide services.

Primary consumers involved in the planning process stressed the need and desire for education regarding medications and wanted this reflected in the model. Consumers who are taking medication want the clinician with whom they are working to explain the benefits and side effects of medication to them.

Another important issue in the area of clinical services identified by some consumers is the need for greater attention to past traumatic experiences and better access for people of color. Many priority clients receiving DMH services have histories of abuse (physical, sexual and emotional). Often, refugees and immigrants have experienced extreme trauma in their native countries as a result of oppression and war, or during their flight to this country. Consumers noted that DMH clinicians need more training to deal effectively with these issues.

Finally, many of the women who are receiving DMH services expressed concern that greater attention needs to be focused on women's issues. They requested that DMH make available clinicians who are specifically trained in responding to the unique therapeutic needs of women and work toward ensuring that these specially trained and credentialed clinicians are eligible for reimbursement by third-party payors (i.e. insurance companies and Medicaid). Reimbursement for the services of these clinicians must be accomplished through legislation.

Goal

The goals of clinical services are to: provide timely evaluation/assessment and psychiatric treatment to consumers who are experiencing an acute or long-term mental health disorder; reduce the incidence and length of hospitalization by providing treatment needed for community living; enhance the quality of life and well-being of priority consumers; reduce the symptoms of serious mental illness through the provision of psychiatric treatment and/or medication.

Eligibility

Services are provided to consumers who request DMH funded/operated mental health services directly, by referral from the DMH Area, or through a referral initiated by a third party. Priority must be accorded to consumers referred by the DMH Area office and in accordance with the DMH policy on eligibility criteria. Referrals for forensic evaluations are made by the courts, correctional facilities, and the Parole Board.

Description

The service types in this category include outpatient services, psychiatric day treatment and forensic evaluation.

Outpatient services is an office/center-based program for adults and their families who have been assessed as needing psychotherapy, counseling or medication monitoring. Services include evaluation and assessment for all persons requesting mental health services, short-term services for persons experiencing an acute mental health disorder and longer-term services for DMH priority consumers. Through outpatient services consumers may receive individual, family, group or couple therapy, supportive counseling, medication monitoring and education, psycho-educational groups, outreach and assistance in gaining access to entitlements.

Psychiatric day treatment is designed to serve consumers in need of stabilization through an active treatment environment. The goal is to maximize an individual's level of functioning in the community and to prevent the need for acute inpatient care. This service is primarily used by persons recently discharged from the hospital or individuals in immediate danger of re-hospitalization, and the typical length of stay is

three to six months. Consumers may expect to receive individual or group therapy, milieu therapy, and educational and socialization activities designed to enhance self-esteem.

Forensic evaluation provides evaluation, assessment, and recommendations for treatment for court-involved persons in a court, correctional, or other outpatient setting. Court-based evaluation and assessment is provided for criminal defendants, persons believed to have a mental illness and in need of hospitalization, persons who are believed to have a substance abuse problem and need involuntary treatment, and juveniles charged with delinquency. County-based services provide evaluation and recommendations for treatment for individuals who are incarcerated in county correctional facilities or MCI Framingham, or who are under evaluation or supervision of the Parole Board.

Support Services

A comprehensive adult mental health service delivery system must provide an array of support services which enable primary consumers to live in the community and pursue their goals. In addition, there must be a recognition of the critical role families often play in providing assistance to their family members with a serious mental illness. These efforts are supported by the Department which has also made a commitment to promote primary consumer involvement in the development and provision of mental health services. One aspect of that commitment is reflected in the support services category of the adult model.

Goal

The goals of the services provided through the DMH support services category include:

- assisting consumers in their efforts to develop the necessary skills to live successfully in the community;
- supporting families in their efforts to assist primary consumers in living independently in the community;

- developing leadership and peer support skills of primary consumers; and
- providing highly individualized services for primary consumers with specialized needs.

Eligibility

DMH priority consumers and their families are eligible for support services.

Description

The service types included in this category are drop-in centers/social clubs, consumer/family support, community support, and individual support.

Drop-in center/social club provides an informal and welcoming environment for consumers to come for social/recreational activities and peer advocacy. The components of this service may include: peer support; meals on a regular basis; assistance to individuals to meet basic human needs; membership in a community of peers; activities which foster social support networks; recreational opportunities; and self-help skills.

Consumer/family support programs provide supportive, rehabilitative and educational services to people who have a long-term and serious mental illness, and their families. The services are designed to reduce the stigma related to mental illness and to recognize that consumers and their families are a vital link in the continuum of care. The goals of the consumer and family support services are: to enable people who have a mental illness to live as independently as possible; to enable consumers to better care for themselves and to enable families to better care for their mentally ill family members; to promote the view of consumers and families as caregivers and reactors rather than as causal agents; and to encourage improved communication among primary consumers, families, and mental health professionals. The components of these services may include: self-help/peer support groups; respite services; independent living services for primary consumers; anti-stigma projects; education programs, workshops and conferences for families, consumers and the public; companion programs; outreach services; technical assistance to consumer and family groups; and information and referral.

Community support is designed to provide necessary support to increase an individual's capacity to remain in the community by avoiding unnecessary or inappropriate psychiatric hospitalization. This service responds to priority consumers who require intensive support to live successfully in the community; those who will not use existing mental health services; those who rely heavily on the emergency service system for support and/or who repeatedly use emergency services; and those long-term patients who are ready for discharge but remain in an inpatient facility because of the unavailability of community placements. This service is available to the most seriously disabled priority consumers. The components of the service include: aggressive outreach to primary consumers who have traditionally had a difficult time becoming engaged in the service system; assisting primary consumers by providing necessary support and skill training in the areas of community living, transportation training, basic ADL skills, and mediation and advocacy; assisting primary consumers in gaining access to services of their choice; assisting primary consumers in developing a natural support network; and providing intensive support during a psychiatric crisis.

Individual support services may fund a contract to provide services required by an individual in an emergency or transitional situation, or in order to prevent psychiatric hospitalization. The funds for these individualized services are authorized on a case by case basis. Components of this service may include: transportation which allows the primary consumer to get services required to prevent hospitalization; short term residential placements in an emergency or transitional situation; other short term support services not currently available which will enable the consumer to maintain himself or herself in the community; highly specialized individual residential placements which are not currently available in the Area; and, specialized support services required by cultural or linguistic minorities which are not currently available in the Area.

Adult Service System Objectives

The following are objectives for achieving the goals of the Adult Service System. The objectives identified focus on rehabilitation, consumer involvement, housing services, populations with specialized service needs, and promotion of human dignity through specialized service needs, and promotion of human dignity through quality assurance, citizen monitoring and other evaluation mechanisms. Following each objective is a series of implementation strategies which reflect the priorities of the Department of Mental Health for the coming year. This year, as noted before, will be a year of transition in Massachusetts state government. The Department of Mental Health has made a commitment to move forward to implement its model for an Adult Service System, but may need to make adaptations based on changes in state government and/or continued budget reductions. It is anticipated that the strategies outlined here for achieving the goals of this system can be implemented in an environment of change and fiscal constraints.

Integration of rehabilitation principles and programs into the Department of Mental Health service delivery system.

- conduct a series of nine rehabilitation institutes for mental health staff on issues such as: supported housing; clinical understanding of the rehabilitation process; independent living, recovery and empowerment; consumer case management; and a specific institute designed for psychiatrists on rehabilitation.
- Facilitate the continued development of a coalition of members of clubhouse programs. This group began meeting in November, 1990 and continues to meet monthly. In addition, a committee of family members have been active during the past two years in advocating for further clubhouse development. Although the two are separate entities, they have worked collaboratively to organize specific advocacy events and activities designed to promote clubhouse concepts and programs.
- Foster the further development of consumer self-help and advocacy organizations through continued support of the independent living center programs, M*POWER, and other consumer empowerment groups. This support will continue to be in the forms of financial and technical assistance, as well as increased opportunities for these groups to impact the policy and program development of DMH.

- Minimize the impact of budget reductions on those services which assist DMH consumers to obtain and keep meaningful work, maintain a stable living situation, and pursue educational goals. The Department will maintain the prioritization of residential services, clubhouse and supported employment services as well as case management services.
- Develop a statement which sets forth the program philosophy and standards for rehabilitation programs within DMH inpatient services.

Increase consumer involvement in planning, as well as policy and program development activities.

- Identify consumers interested in providing training for mental health staff on consumer empowerment, learned helplessness, preferred services, and effective listening. Provide opportunities for mental health staff to receive training from consumers. Through M*POWER, the Northeast Independent Living Program and clubhouse programs, the Department will identify individuals who are interested in providing training for mental health professionals. A series of workshops for DMH staff will subsequently be organized.
- Through the rehabilitation project interested consumers will receive training on organizing meetings, advocacy, the budget process and relevant legislation. Interested consumers from clubhouse programs have already received training on organizing and conducting meetings, advocacy and the budget process. Approximately 30 consumers have participated already in these trainings.
- Conduct additional consumer forums.
- Provide opportunities for consumer participation in policy development. Consumers have been actively involved in a task force convened to develop DMH policy related to room restrictions, seclusion and restraint issues. As other policy development activities occur DMH will include consumers in the work-groups organized to address the issues.

- Explore and implement options for increasing consumer operated services, such as peer support, consumer case management, and consumer assisted transition from hospital to community. A work- group has been established to explore options for increasing consumer involvement in the operation of residential services. This work-group will examine a variety of issues, including strategies for transitioning traditional residential programs to ones that are based on a supported housing model or ones that are based on a supported housing model or consumer operated services. In addition, DMH is submitting a grant application to NIMH on the development of consumer case management services. If the grant is awarded, DMH will have the opportunity to establish a demonstration project on consumer case management. The rehabilitation project is also exploring strategies for increasing the role of the consumer operated Northeast Independent Living Program in assisting in the transition of patients from the hospital to the community.

Implement DMH housing agenda.

- The FY'91 Housing Agenda includes the planned development of 354 additional community residential beds. Specifically, the types and numbers of beds may be categorized as follows:
 - General Residential Beds Under Development: 158
 - Metropolitan State Hospital Downsizing: 40
 - National Institute of Mental Health (NIMH)
Study of Homeless Adults with Mental Illness: 68
 - Case Managed Housing (SHARP): 29
 - Latestarts from FY'90; Previously Funded
General Residential Beds: 8
 - Stabilization (re-siting) of Existing Programs in
New, More Secure Buildings: 51
-
- 354

Improve access to appropriate mental health services for populations with specialized service needs.

- Despite the reductions in the DMH budget, maintain and, if at all possible, expand funds for interpreter services for persons whose primary language is not spoken English.
- Provide additional cross-cultural training and technical assistance to mental health staff and to management staff on development of appropriate services for multicultural populations, including refugees and immigrants. At least 75 additional DMH staff will receive training during FY'91.
- DMH has convened an inter-agency task force to identify the service needs of young adult consumers who are deaf and to develop strategies to meet those needs. A survey instrument has been developed by the group and will be distributed this spring.
- Conduct a training conference in June on specialized issues in mental health service delivery for geriatric consumers. A planning group has been meeting to organize this conference. Potential topics include medication, health care, and developing collaborative relationships at the local level between the geriatric services network and mental health system.
- Maintain activities under the NIMH funded research grant on integration of alcohol/substance abuse treatment with traditional psychiatric inpatient services for persons who are dually diagnosed as mentally ill and having a substance abuse disorder.
- Convene a work-group of DMH staff interested in enhancing DMH service delivery to primary consumers with substance abuse disorders. This work-group will begin meeting in February to identify gaps in the service system for this population and how these needs may be addressed.
- Maintain the work-group that has been addressing strategies for the recruitment of expatient/consumer staff. In addition, DMH will work with local colleges (i.e., the Boston University School of Social Work and the Refugee Paraprofessional Training Program) to recruit bilingual/bicultural staff.

- Continue active efforts to place medically involved individuals currently inappropriately placed on DMH inpatient units to more appropriate settings.
- DMH is conducting a study of persons served by DMH in the shelters to more clearly identify their service needs.
- DMH is resubmitting a grant application to NIMH which will continue shelter support services and expand housing assistance through this grant if funded.
- DMH is analyzing current allocation of positions to homeless shelters to identify any need for redistribution of these positions.

Ensure that the human rights and human dignity of all consumers are maintained through quality assurance activities, the citizen monitoring program, the human rights office, and additional specialized initiatives.

- Continue active citizen monitoring program through training of citizen monitors, site visits to all facilities by citizen monitors, quarterly meetings at each facility to review conditions, and quarterly meetings of senior administrative staff with monitors to assure response to issues raised during monitoring site visits.
- Quality Assurance activities at the inpatient units will continue to focus on the development of infra-structure (policy and procedures) toward attainment of accreditation and certification. Mock site visits will be conducted at targeted facilities and a work plan developed to assist facilities in gaining certification or accreditation. In community programs, Quality Assurance activities will be focused on the development of standards for DMH services. During FY'91 standards for residential programs and clubhouse programs will be developed.
- A process will be established to integrate information from human rights, quality assurance, internal affairs, and the citizen monitoring program into a quarterly report for senior managers on each inpatient facility.

- Site visits will be conducted at each inpatient facility specifically to review efforts to maintain a high standard of consumer dignity and human rights. A team comprised primarily of ex-patients and consumers will be organized for this purpose. This team will serve as a work-group charged with the responsibility to explore options for enhancing the Department's efforts in the area of consumer dignity and human rights.

Child and Adolescent System Model

Goals and Background

For more than a decade, the Department of Mental Health through its Division of Child-Adolescent Services has been philosophically committed to providing individually oriented services to seriously mentally ill and severely emotionally disturbed children in their home community whenever possible and to promoting family preservation and family involvement in the treatment of children. However, from 1984 until the present, service system development has been driven by the need to comply with Executive Order 244, which mandated that no person under the age of 19 be placed with adults in state inpatient facilities. Thus, until recently, the Department's fiscal focus has been on developing alternative placements to adult inpatient units such as adolescent inpatient facilities and residential programs for the most severely disturbed children and adolescents. Data from the field now indicate that from a statewide perspective, although geographic distribution of resources is uneven, sufficient beds are available to serve those seriously mentally ill and severely emotionally disturbed children and adolescents who must be removed from their homes for their own safety or for that of others. Therefore, the Department will focus its future efforts on the development of home and community based services.

Facilitate treatment of children in their own homes and communities.

The Department recognizes that, in some cases, hospitalization or residential placement could be avoided or shortened if alternative appropriate services were more available. It recognizes the need to make emergency and crisis services more accessible and to further develop and expand services such as intensive home-based treatment offered several hours a week over a period of months, parent aides, day treatment programs, after school therapeutic activity programs, and respite care. Case studies and successful models operating in other states have shown that families who have these types of services available to them have proved able and willing to maintain their children at home, or to take them back home after a short out-of-home intervention.

Improve early identification and treatment of children and adolescents at risk of serious mental illness or severe emotional disturbance.

In addition to serving the seriously mentally ill and severely emotionally disturbed, the Department acknowledges its additional responsibility to improve services for children and adolescents at risk of serious mental illness or severe emotional disturbance and to educate people about the benefits of early intervention. The Department operates within the NIMH definition of at-risk as developed by the Child and Adolescent Service System Program (CASSP), which defines youth at risk as those children and adolescents who, as a result of environmental and/or biological factors have a high probability of becoming seriously mentally ill or severely emotionally disturbed. This group includes, but is not limited to, those youth who are homeless, either as part of a family unit or alone; those living with parents who are unable to provide adequate care and nurturing, including drug-addicted parents; those who have been victims of violence, who abuse drugs, who are HIV infected and/or those who have a family history of psychiatric illness.

Expand activities which empower families to help their children.

In order to better serve the seriously mentally ill and the severely emotionally disturbed and also those at risk within the most normative environment possible, the Department intends to place greater emphasis on the following activities: support of programs in the community which foster healthy child and family development; engaging the child's family and community in early identification of mental health problems; provision of educational, emotional, and respite support for families who have children with mental health problems to increase their capacity to help their children; and provision of more customized treatment planning and problem management which builds on the strengths of the child, the family and the culture, and which takes full advantage of the resources of the community.

Reduce barriers to treatment.

Barriers to treatment exist at the level of the client, the program, and the underlying bureaucratic system. The task of building a system to assure early identification of problems and ready access to treatment is one which the Department must tackle in coordination with a wide variety of local and state agencies, public and private. Many children and adolescents who exhibit severely disturbed behavior are known by agencies and organizations in their communities; however, these children do not get mental health treatment until there is a psychiatric emergency. The

causes for this are various: the fact that there is a mental health problem may not be recognized; mental health treatment settings are often forbidding; there may be stigma attached to mental illness; the family and the community agencies may not know how or where to get help; there may be language problems; and services may be physically inaccessible. Finally, there may be a long wait for help once application for service is made. Since services are delivered at the local level, a rigorous effort must be made to define how DMH can best work in cooperation with each community to assist seriously mentally ill and severely emotionally disturbed youth to receive appropriate services.

Facilitate early treatment of mental health problems.

At the level of primary prevention, mental health should be a partner with other agencies in the development of neighborhood-based family resource and support centers. Although some children may have a mental illness which is biologically based and thus not preventable given the current level of medical knowledge, family resource centers can assist all families in understanding child development, in identifying varying kinds of problems and resources for help, and in improving parenting skills and the child and family's adjustment to each other. These centers may also serve as the underpinning for more specific early intervention efforts.

At the level of secondary prevention, effective intervention, regardless of the presenting problem, requires that a child and family be looked at holistically. In order for a comprehensive service plan to be developed the child and family's needs must be examined in the areas of prevention, early intervention and family support services, including: respite care; mental health services; social services; educational services; medical services; vocational services; recreational services, and social and spiritual supports.

Standardized Intake.

Early recognition of a variety of problems can be facilitated through use of a standardized intake tool which is bilingually and biculturally sensitive and whose use is coordinated among agencies and service providers. As part of a standardized intake, the Department of Mental Health in conjunction with other child-serving agencies should adopt a mental health screening and assessment tool which can be used by community agencies and child welfare workers as well as mental health professionals. If it appears from the screening that a child needs help, there needs to be a clear procedural path which the caregiver making the assessment can follow in order to gain such assistance.

Improve the accessibility of services.

To facilitate access to mental health services and joint treatment interventions with community caregivers, the Department must provide information about its services, where and how they are provided, and how one gets them. Services, particularly those geared to cultural and linguistic minorities, must be revamped and expanded and put where the children and their families can most easily reach them. Ideally, there should be a neighborhood based distribution of mental health services. Although the service location may vary by community, in many cases it may mean having mental health services in the schools, as part of a comprehensive health program. If so, a plan for delivering services during school vacations needs to be developed. It may mean having mental health workers outstationed in some generic community agencies, it may mean contracting with a non-mental health agency to become a mental health provider, and/or it may mean having mental health consultation available to other community agencies such as social, recreational or religious agencies which serve children. A critical factor is for Area staff to know and be known by local organizations.

Improve treatment outcomes through increased participation of families and increased ability to respond to differences among families and cultures.

The manner in which help is given needs to be flexible and responsive, reflecting the wants and needs of the family and the capacity of the potential helpers. It should be noted that "family" as used here is not limited to mean parents or even blood relatives, but is inclusive of those who serve as family to the child. In some cases the child and his family may best receive help with their mental health problems from someone who is not a mental health specialist, but a caregiver who receives technical consultation from a mental health professional as requested and needed. In other cases, the child and his/her family might best be referred elsewhere for treatment. For homeless children, the Homeless Services Unit of DMH has recommended that the Department arrange for evaluations at the shelter sites by qualified mental health professionals, as staff assigned to shelters are not trained to do mental health assessments of children, and parents are reluctant to take their children to DMH outpatient sites.

Treatment should be individualized and family based, and thus sensitive to the child's culture. The wants of the family as well as the professional's assessment of "needs" have to be negotiated as part of the individualized treatment plan. The child needs to be seen and treated in the context of

the family, and the child and family should receive those services which will enable the child to remain in his or her own home or community. No child should be removed from home unless there is compelling reason to do so. The concept guiding treatment should be "normalization", enabling the child to be able to function in the milieu from which s/he comes unless it is unhealthy. The Department needs flexibility to be able to build a variety of services around the child and family, as family situations and strengths will differ. Not only is flexibility needed in the kinds of services provided, but existing programs also need to be able to tailor their programs to individual clients.

It is expected that the variety and types of services needed will vary by family. In one case a family may need only respite care and outpatient treatment, and in another situation a family may need day treatment, home-based treatment, linkage to recreational programs, and financial assistance. Special attention must be paid to those children whose diagnosis suggests that they will need services throughout their lives, albeit at varying levels. To assure continuity of care for these children, long-range plans should be formulated addressing services through adulthood and a system for regular contact and case monitoring should be developed. Special attention must also be paid to the needs of children who are without permanent families and to realistic planning for them.

Improve capacity to provide comprehensive yet coordinated services to children and families.

Interagency cooperation in developing and implementing a treatment plan is critical. From the family's perspective, they should be dealing with one treatment system, "a seamless system" which may involve several workers. Negotiating the various bureaucracies and coordinating their efforts should be the work of the staff within those bureaucracies and not the family's task. At a minimum, the family, school, DMH, the referring community agency and other organizations to which the family feels strongly connected, such as a church, should actively collaborate in determining what services should be provided. Other potential service providers should be brought into the process as appropriate. It is critical that a person whom the family and child trust be the one to follow through to assure that wanted services are received. This person whom the family perceives as the actual "case manager", i.e. the person who brokers services for the family and who assists the family in dealing with the bureaucracy, may turn out to be someone who works with the DMH case manager who has official responsibility for providing case management.

Child/Adolescent Prevalence Measures

Prevalence estimates for children and adolescents in Massachusetts were calculated based on a model originally developed by the state of North Carolina. Overall population rates were adjusted for each DMH Area using sociodemographic analyses from the 1984 Needs Assessment.

The table below shows the total number of children and adolescents estimated to be at risk of serious mental illness or severe emotional disturbance in each Area. In addition, it shows the number estimated to be in need of public mental health services.

Child/Adolescent Prevalence Estimates

	A Number At Risk 11.80%	B Need Service 5.00%	C Public Service 2.50%
Areas			
Western Mass.	23,463	10,230	5,115
Central Mass.	21,943	8,022	4,011
Merrimack Valley	15,882	6,330	3,150
North Shore	16,606	6,522	3,262
Metro West	16,278	4,807	2,404
Metro South	16,103	4,781	2,390
South West	16,414	6,366	3,183
South Shore	18,323	6,883	3,441
Boston	22,740	17,170	8,585
Child Totals	167,752	71,081	35,540

Column A: the group of individuals most likely to exhibit current or future diagnosable mental illness or emotional disturbance.

Column B: the number in need of professional mental health services at any one point in time.

Column C: those likely to need public mental health services; the Department's priority clients.

Child/Adolescent Service Model Components

Although the Department's direct services are focused on mental health, it is understood that the broad range of services which these children need is a responsibility shared by many state agencies who must work collaboratively on behalf of the client. Mental health policy and program development will continue to be coordinated with state agencies such as the Department of Education, the Department of Social Services, the Department of Public Health, the Department of Youth Services, and the Department of Public Welfare.

The specific mental health components of a comprehensive continuum of care are listed and then described below.

Emergency Services

Case Management

Residential

- Crisis Stabilization and Acute Hospitalization
- Long Term Hospitalization and Intensive Residential Treatment
- Group Living and Therapeutic Family Care
 - Supervised independent living
 - Alternative family living
 - Group living
 - Therapeutic camp

Non-Residential

- Day Programs
 - Day treatment
 - After school and weekend programs
 - Specialized therapeutic summer programs
- Home-based crisis intervention, assessment and treatment
- Outpatient services
- Consultation and Education

Emergency Services

Emergency services are available 24 hours a day in each of the Department's nine Areas, and are organized to serve both children and adults. A fuller description of Emergency Services may be found in the section on statewide services (see page 51).

Case Management

Case management services are organized to serve both children and adults and each Area has specified children's case managers. See section on statewide services for fuller description (page 55).

Residential Services

The Child/Adolescent model uses the heading "Residential Services" to include acute hospitalization, crisis stabilization, long term hospitalization and residential treatment and group living.

Acute Hospitalization and Crisis Stabilization

Goal:

When a child or adolescent is experiencing a psychiatric emergency, the Department intends to use the least restrictive, most appropriate means available to stabilize the child and family. If the crisis intervention services available through each Area's emergency service system and/or in-home crisis intervention cannot meet the child's need, the Department will address the problem through crisis stabilization services offered in the community or in a hospital setting. The goal of acute hospitalization is to stabilize a child or adolescent experiencing psychiatric crisis who cannot be treated appropriately in a non-medical psychiatric setting.

Description and Function:

Crisis stabilization and acute hospital services are available 24 hours a day, 7 days a week and include: psychological diagnostic procedures; observation treatment modalities including psychotherapy, vocational rehabilitation, recreation therapy, and milieu therapy; supportive services and room and board. Crisis services offered within a hospital setting also include medical diagnostic procedures and medical care and treatment.

Community based crisis stabilization provides 30 days or less of supervised residential living to a child in psychiatric crisis in a setting other than the child's home. This service is provided until the child is stabilized, until a longer term residential setting is secured, or until the need for hospitalization is determined and the child is hospitalized. Residential respite, although a separate short term service, may be considered as an aspect of crisis stabilization because it addresses the needs of families or custodians who need periodic relief from the constant and often stressful care of an SED child living at home. While in a respite care setting, the SED child receives care which addresses his/her health, nutritional and daily living needs.

Objectives:

The Department's systems goals are to ensure that children are hospitalized only when medically necessary, to assure that sufficient community services are available to address psychiatric crises in the community, and to maintain high quality services within publicly funded programs which do not exceed their planned service capacity.

Long Term Hospitalization/Intensive Residential Treatment

Goal:

The goals for long-term hospitalization and intensive residential treatment are to provide a secure and therapeutic environment to stabilize and control inappropriate behavior of severely emotionally disturbed children and adolescents.

Eligibility:

Both services are geared to youngsters who meet the DMH criteria for commitment to a mental health facility.

Description:

Hospitalization beyond a 90 day acute period is available for children and adolescents who require continued intensive medical treatment to achieve stabilization and/or problem remediation. Average length of stay is not expected to exceed 9 months. Intensive residential treatment services are offered to those youngsters who are medically stabilized but who are highly aggressive. Emphasis is placed on controlling the child's violent and/or self-destructive behavior and on establishing positive, appropriate behavior. Average length of stay is expected to be 18 months.

Long-term inpatient services include diagnostic procedures if indicated; treatment modalities include medication, psychotherapy, vocational rehabilitation, recreation therapy, and milieu therapy; medical care and treatment; supportive services; and room and board.

Intensive residential treatment programs are the most highly structured non-hospital services offered. They offer secure residential treatment and provide a therapeutic milieu offering individual, group, and family therapy, an on-site educational program, and psychopharmacological

treatment. Activities emphasize social skills, emotional and cognitive development, daily living skills, vocational skills and recreation. These programs strive to prepare youth for community living in a less restrictive setting.

Objectives:

The Department's goals are to maintain high quality long-term care within publicly funded units which do not exceed their planned service capacity; and to ensure that youth are discharged to less restrictive treatment settings as soon as it is clinically appropriate.

Group Living and Therapeutic Family Care

Goal:

The goal of group living and therapeutic family care programs is to provide a safe and therapeutic living space with appropriate psychiatric intervention for severely emotionally disturbed children who cannot be treated within their own homes, yet who do not require psychiatric hospitalization or a highly restrictive intensive treatment program.

Although it is the Department's aim to treat the child in his/her home whenever possible, this is not always feasible. As it is the Department's goal to place the child in a clinically appropriate setting, funding continues to be targeted to a range of program types which vary in therapeutic intensity and duration. The Department aims, through treatment, to involve the child with the surrounding community and to facilitate client movement to less restrictive alternatives which may include a return to home as the client's needs change.

Description:

The Department intends to provide the following types of service: supervised independent living; alternative family living; short term therapeutic camp; and residential group living ranging in degree of restrictiveness from moderate to high management. The services and target group vary according to the program type.

Supervised Independent Living

In supervised independent living, older adolescents live with trained adults in a home or apartment. Activities include emotional, physical and cognitive development, social integration, vocational skill building, and skill training towards living on one's own.

Alternative Family Living

This program is offered to severely emotionally disturbed children who cannot remain in their own homes and who need more caretaking than that provided in supervised independent living. Children live in homes with specially trained and locally supported parent substitutes. These parent substitutes receive more intensive training than do regular foster parents trained by the Department of Social Services. Support systems help them work with SED children. In a variant of this model, parent substitutes who are professionally trained work intensively with the SED child to provide for his/her basic living, therapeutic, socialization, and skill-learning needs. Professional parenting requires skills above those normally found in alternative family therapeutic homes.

Group Living

Group living is offered to children for whom a more structured program is essential. Group living situations vary in degree of supervision and the degree to which the child is free to participate in community life. In moderately supervised group living, children live in a community and attend public schools or day treatment and education programs; older children may have job placement. These group homes provide healthy adult role models; group, individual and family counseling; liaison services to mobilize community and family resources; and social, emotional and cognitive training. High management residential group living provides these same services in a more highly structured and supervised setting. Children may attend school or other programs in the community or receive these services within the facility. Length of stay in both moderate and highly structured settings is based on the needs of each child.

Therapeutic Camp

This residential program is available to children 6-18 years of age who have mild, moderate, or serious problems. Within a therapeutic milieu, recreational and education experiences with supervised peer interaction are provided by healthy, adult role models under therapeutic supervision. This service is provided during weekends

through the year and/or during 6-9 weeks in the summer. Liaison services are also provided to promote community and family interaction.

Non-Residential Programs

Non-residential programs include day programs, home-based treatment, outpatient services and consultation and education.

Day Programs

Goal:

The goal of day programs is to provide therapeutic intervention on a regular and intensive basis and thereby enable severely emotionally disturbed children/adolescents to live in the community.

Description:

Day Treatment

Day treatment is provided to children with moderate to severe problems who have difficulty participating in partial or full public school programs. The service is often provided in conjunction with a residential treatment program. Specialized staff provide a structured, therapeutic, and educational program which can include academic training, vocational training, social skill training, individual and group counseling/therapy, recreation, transportation, and services to parents. Services may vary in intensity as reflected in staff to client ratios. Services are generally provided between 4 and 8 hours a day, 5 days a week.

After School and Weekend Programs

These programs are available to school age children who need care and therapeutic intervention after school hours to enable them to remain in their own schools and communities. The services incorporate individualized programming in the developmental skill areas and also provide intensive therapeutic support and social rehabilitation. Services are provided after school, evenings, and weekends.

Specialized Therapeutic Summer Programs

These day programs are available to severely emotionally disturbed children who need summer programs to meet their individual treatment needs and the treatment needs of these families. Services are intended for those children at high risk of psychiatric crisis during unstructured summer months and whose needs are not met in other generic summer programs. Activities in these programs occur in a variety of settings including community recreational resource centers and specialized day camps. Activities include group socialization experiences and recreation; they are supervised by individuals who are knowledgeable about severely emotionally disturbed children.

Home-Based Treatment, Outpatient Services, and Consultation and Education

Goal:

The goal of these services is to provide the treatment and support necessary to both children and their families to enable a child to remain at home.

Description:

Home-Based Services

These services are provided in the home setting to a child or adolescent and his/her family or family substitute. In-home services include intensive crisis intervention, environment stabilization, homebuilder activities, parent training, counseling, and companion or other outreach and support activities. In addition, respite care in the home can be provided on a planned basis for weekends and on an emergency basis.

Outpatient Services

Outpatient services offer ways to improve or stabilize the family living environment of the child, to minimize the necessity of out-of-home placement of the child, to assist parents and family members to understand the effects of the child's disabilities, and to assist parents and family members to affect their child's developmental growth. The category of outpatient services encompasses diagnostic evaluation, behavioral assessment, individual, group, and family treatment. For families it includes family therapy, counseling for family members, parent training and parent support groups. Combinations of these services may be made available to the parents, siblings, and extended family members of children who have

varying levels of disturbance. Also included in this category are such collateral services as case conferences, treatment planning, and conferences and case consultations in conjunction with other community agencies, such as the local schools and DSS.

Outpatient services are provided to children with mild to moderate problems who can otherwise function in their home environment, provided that such children meet the DMH eligibility criteria for these services. For more seriously emotionally disturbed children, outpatient services are often provided in conjunction with other more intensive services such as residential programs and day services. Direct treatment activities provided by area mental health programs to children and adolescents in school settings are also considered as being in this category.

Consultation and Education

Consultation and education in regard to treatment, prevention, and resources are provided to community agencies and personnel involved with children and adolescents in order to provide a community environment which will be supportive of and capable and willing to deal with severely emotionally disturbed children and adolescents. Services include training around general and specific child and adolescent issues, consultation to staff in community based agencies related to program development and development of a therapeutic milieu for children and adolescents, and dissemination of information to involved community members on both general and specific issues relating to children and adolescents.

Service Targets and Capacity

In order to determine the amounts of each service needed statewide, the Department has adopted a formula-based model based on that used in North Carolina, Florida and Washington, D.C. It should be noted that within each component of the continuum there are many service types, and also, that progression along the continuum is not linear. A particular child may use several services at one time; for example, a child's family may be receiving intensive home based treatment and at the same time a child may be enrolled in a day treatment program.

Area service targets will be calculated from the statewide figures on a population basis. Priority will be given to those Areas which currently have the fewest resources in order to create an equitable distribution of services. Although hospital and I RTP beds are not evenly distributed geographically, such services are available on an equitable basis to

clients from across the state. The distribution pattern of these most restrictive services provides added impetus to focus on those services which enable the child to be treated at home or in his or her home community.

<u>Statewide</u>	<u>Measure</u>	<u>Current capacity</u>	<u>Goal</u>
Emergency Services	no separate target for children		
Case Management	clients	1,165	4,977
Inpatient & Residential			
<i>Crisis Stabil. & Acute Hospital</i>	beds	181	188*
* It should be noted that this number includes 7 acute care beds at the Gaebler Children's Center as of 7/1/91.			
<i>Long Term Hosp. & Intensive Res. TX</i>	beds	111	104
<i>Group Living & Therapeutic Family Care</i>	beds	340	976*

* It is anticipated that most of the increase will be in the category of therapeutic family care; this figure reflects a decrease in 7 long-term care beds at Gaebler Children's Center.

Non-Residential

<i>Day Programs</i>	slots	205	2,132
<i>Home based</i>	slots	42	296
<i>Outpatient</i>	slots	4,466	10,341
<i>Consultation & Education</i>	No statistics available, therefore no measurable goals set for this service		

Financing the Child and Adolescent Service System

The Department intends to create a more geographically balanced service system through reducing the inequity among the Areas. Given the current fiscal situation, this translates into making larger budget cuts in those Areas which have proportionately more resources. A formula has been developed, based on a ranking of Areas by need and by resources, to guide future budgetary decisions. This is an ongoing initiative.

The Department is working toward having all eligible DMH funded programs become certified as "Psych under 21" Medicaid providers. Retention by the Division of Child-Adolescent Services of federal reimbursement from service programs that were not previously reimbursable is being looked to as a means of minimizing the cuts which would otherwise have to be made to the community service system as a result of current fiscal constraints. In the future, federal reimbursement is expected to provide funds for expansion of community services.

Four of the state's five Intensive Residential Treatment Programs (IRTPs) have already become accredited by JCAHO and are in the process of applying for certification as "Psych under 21" Medicaid providers. The fifth IRTP will apply for JCAHO accreditation and Medicaid certification in 1991. In addition, the Gaebler Children's Center is applying for certification as a "Psych under 21" Medicaid provider. DMH is able to retain 100% of these revenues up to a limit set annually by the Legislature. A small portion of the federal reimbursement will be utilized to maintain these programs at the standard required for reimbursement, while the bulk of the federal dollars will be used to minimize the volume of cuts in the community service system. It is expected that the four IRTPs and the Gaebler Children's Center will achieve certification during 1991.

The Department is also working toward having all eligible programs become certified under the Medicaid Rehabilitation Option. Federal reimbursement generated by these programs will be used to minimize the cuts which would otherwise have to be made to the community service system as a result of the current fiscal crisis. In the future, federal reimbursement is expected to provide funds for development of additional community programs. It is expected that programs will be certified under the Rehabilitation Option beginning in June, 1991.

The Department has also taken steps to increase the availability of insurance payment for alternatives to hospitalization. Through language included in the state's FY'91 budget, a legislative task force on mental

health inpatient insurance was authorized to meet and develop recommendations for amending the state's mandated insurance benefit to encourage coverage for previously non-covered services such as home-based treatment. The task force is supposed to develop a report for the Legislature by Spring, 1991 but as yet, no members have been appointed by the administration or the Legislature.

Human Resource Support

The recession in the Massachusetts economy has eased the personnel shortage for mental health programs noted in the Comprehensive Plan of September, 1989. The nursing shortage, although continuing, has abated in intensity. The Division of Child-Adolescent Services continues to participate in joint nurse recruitment efforts with the Central Office Human Resource Development staff and staff responsible for the state hospitals, in accordance with a comprehensive nurse recruitment strategy developed in FY'89. Finding numbers of qualified staff for residential treatment programs is not a problem at present.

The major staffing problem facing the Division is recruitment of minority staff, and particularly bilingual staff, for community based services and residential and inpatient programs. The Division will be hiring multicultural specialists to develop training about services to minorities for all children's mental health workers. In addition, the Professional Advisory Committee to the Division of Child/Adolescent Services will be developing strategies to increase the number of minority caregivers in the mental health system.

Consumer Initiatives

The Department of Mental Health provides funding for the Parent Professional Advocacy League (PAL) which works in collaboration with the Federation for Children with Special Needs. The goals of PAL are to improve parent-professional understanding and collaboration; to empower parents of children who have severe emotional disorders or mental illness to serve as partners with professionals through education, information sharing, and mutual support networks; and to promote effective advocacy for these youth and their families. Within the past year PAL has established a toll free telephone, accessible for TTY users, in order to make their services more readily available across the state.

In addition, the family support group of the Western Massachusetts Alliance for the Mentally Ill provides support, education and information sharing for families of children with serious mental illnesses. Besides advocating for better treatment and needed services, the support group tries to remove the stigma of mental illness by openly talking about problems and regularly invites professionals in the field of mental illness to share information with family members.

Consumers were actively involved in the shaping of this service model and continue to be involved in the policy and planning activities of the Division. In addition to being key members of the P.L. 99-660 children's planning subcommittee, parents sit on the Professional Advisory Committee of the Division of Child-Adolescent Services. In addition, the Division is reviewing program policies to assure that consumers are represented on program advisory boards and boards of directors of provider agencies.

Child and Adolescent Service System Objectives

The objectives listed below are strategies for realizing the goals of the children's service system.

Objective: Enhance the DMH Area-based service system to facilitate treatment of children in their own homes or communities.

- Assure that in each of the nine Areas clinicians trained in children's mental health are available to provide mental health services on a regular basis and to serve on the 24 hour crisis intervention teams. (August, 1992).
- Work with the adult service system to develop a crisis service capable of serving children and adolescents which may be used for up to 72 hours in each of the nine Areas. (August, 1992).
- Assure that for children and adolescents the ratio of DMH case managers to clients does not exceed 1:25. (August, 1991).
- Develop in each Area a signed memorandum of understanding with the Department of Social Services specifying roles, responsibilities and specific procedures to be followed in regard to crisis intervention, hospitalization and aftercare for children in the care or custody of DSS. (January, 1992).

- Develop affiliation agreements between DMH crisis services and residential programs funded by other state agencies to address crisis back-up, psychiatric hospitalization issues, and clinical consultation for each area. (December, 1992).
- Demonstrate collaborative relationships with schools and other child-serving agencies. (March, 1992).
- Implement an interagency protocol in the Boston Area to assure that out-of-home placements are prevented whenever possible. (December, 1991).
- Develop a plan which specifies how parents of seriously mentally ill and severely emotionally disturbed children are to be involved in service planning. (September, 1991).
- Implement a mechanism for service dollars following the child. (March, 1992).

Objective: Improve interagency coordination in the delivery of services to seriously mentally ill and severely emotionally disturbed children and adolescents.

- Developed a position paper for the new administration which addressed the following issues: (January, 1991).
 - a.) Development of a process by which the child-serving agencies (the Department of Social Services, the Department of Education, and the Department of Public Health, the Department of Mental Retardation and the Department of Mental Health) share budget plans at the Area level and sign off on each other's budget for children's services. The goal is to maximize effective use of resources through budget review which can facilitate cooperative service arrangements and reduce service overlaps.
 - b.) Development of a "children's" budget in each Area. The goal is creation of a budget which reflects collaborative planning. The budget would reflect the program development and expansion activities of the child-serving agencies, would assure that new services met agreed upon Area priorities in a non-duplicative manner and would facilitate joint program funding and/or interagency service arrangements.

- c.) Development of uniform service or planning areas for each of the child-serving agencies.

Objective: Assure early identification and treatment of mental health problems in children and adolescents.

- Determine feasibility of developing a workplan with the Department of Public Health and the Department of Public Welfare for implementing an enhanced Early Periodic, Screening, Diagnosis and Treatment program (EPSDT) capitalizing on the revised regulations for that Medicaid benefit. (September, 1991).

Objective: Empower parents of seriously mentally ill and severely emotionally disturbed children in order to improve their capacity to advocate for their children.

- Develop and disseminate documents describing the services for children and adolescents within of the Department of Mental Health, eligibility criteria, and means of access to services. (September, 1991).
- Assure that each DMH children's service provider has developed documents which explain the program philosophy and treatment process, including admission procedures, procedures for transition to and from other programs, and the parents' role in treatment. (January, 1992).
- Establish a minimum of one parent support/empowerment group for parents of SED children in each DMH area. (September, 1991).
- Promulgate DMH policy requiring each provider agency to have parents of seriously mentally ill and severely emotionally disturbed children and program graduates on its board of directors. (September, 1991).
- Recommend that each Area Board and the Statewide Advisory Committee to the Department of Mental Health include parents of seriously mentally ill and severely emotionally disturbed children. (September, 1991).

Objective: Improve the availability of mental health treatment for children and adolescents from different cultures.

- Develop and begin implementation of work plan for improving cultural competency of child-adolescent service system and service providers to address the following issues: (Dec., 1991).
 - a.) actions needed to enable the mental health system to be seen as helpful resource by multi-cultural communities;
 - b.) identification of changes needed in the organization of service delivery to facilitate service to children and families of diverse cultures.

CHAPTER SEVEN

KEY PROBLEM AREAS: ISSUES FACING THE DEPARTMENT

Meeting Reduction Targets

Impact on Clients and Services

The FY'90 budget cuts eliminated or greatly reduced mental health services to over 11,000 of the estimated 100,000 clients served by the Department. Priority services, such as residential, skills training, and case management services, were curtailed. Clients ready for discharge from inpatient units remained in state hospitals because there were no funds to support residential program openings. The FY'91 budget cut of more than \$48 million has caused further serious service disruption. It is estimated that close to 17,000 additional clients will be directly affected by current service reductions and elimination.

The reductions taken thus far have been implemented in a manner designed to minimize service disruption. However, this has become increasingly difficult with each new reduction. Over the last several years, in recognition of the interdependency of community mental health services, the Department has designed and set about developing a comprehensive community-based system of mental health care. Each component of the system plays a critical role; when one link in the chain is weakened, the reverberations are felt throughout the system.

For instance, emergency services are the gateway to the mental health system for many individuals. Research has shown that successfully maintaining individuals who are in crisis in the community, and avoiding hospitalization, leads to better outcomes for the individual as well as cost savings for the mental health system. When emergency services are reduced, hospital admissions inevitably rise.

Inpatient services are the most costly component of the mental health system. These services are absolutely essential for some clients for certain periods of time, but too often, they become the bottleneck of the system because less costly, more appropriate alternatives are not available in the community. When residential services and skills training programs are reduced, hospital discharges must be slowed.

Staff and Service Reductions: Orderly Transitions

In order to meet reduction targets scheduled for FY'91, several essential activities must occur. The timing of each activity is critical, as each is interdependent upon the other. First, the Department must achieve adequate savings through the current staff layoffs and the reduction of service contracts in the community.

However, savings through staff layoffs are not achieved until the entire round of bumping (as required by civil service/collective bargaining) has occurred, which requires several months. Reductions in service contracts must be carefully timed to allow for client transfers and case closings. The vulnerability of the clients, and the importance of the staff-client relationship requires an orderly transition, which further limits the capability for rapid cost-savings.

In order for the Department to meet its reduction targets, inpatient census must be reduced. Hospital cost-savings are contingent upon the closing of hospital wards and the resulting staff reductions. Major inpatient reduction is planned for Metropolitan State Hospital in Waltham.

Metropolitan State Hospital Downsizing: Critical Activities

Metropolitan State Hospital, with a capacity of 412 and with a census of 291 patients as of 3/23/91, is targeted for eventual reduction to 120 beds. The FY'91 goal is a reduction to 220 beds. This reduction requires the successful transfer of 163 current patients, and the successful diversion of new admissions to other inpatient facilities in the state. However, these transfers and admissions must occur at a time when the other facilities face both reduced resources as well as increasing pressures from reductions in community services, as described above.

In addition to the transfers and admission diversions which must occur, the Metropolitan State Hospital downsizing is also reliant upon the successful development of community housing programs, so that patients awaiting discharge will have appropriate community alternatives. The CHOICE housing program, developed by the Department in cooperation with the Division of Capital Planning and Operations, will play a critical role in the successful discharge of Metropolitan State Hospital patients. Funding for the residential programs requires the savings to be achieved through the downsizing of the hospital, yet the downsizing of the hospital relies upon the availability of residential alternatives. These competing

realities require careful and meticulous planning if DMH is to successfully achieve the necessary reductions scheduled for FY'91 and FY'92.

Reorganization: Challenges and Opportunities

One of the most important steps that DMH undertook to achieve cost-savings was the massive restructuring of the Department's administrative offices. This restructuring presents a number of opportunities for reductions in administrative costs. However careful implementation and monitoring are required to ensure continued reliable and competent management of the Department's programs and services.

The first benefit of the restructuring will be a single chain-of-command throughout the community and inpatient systems. A single individual will be accountable for the care of each client, regardless of what services that client is receiving. Development of an organizational structure which is responsive to communication needs but which retains authority and accountability will be a critical activity for the Department in the coming months.

Citizen participation is another critical component. The Department will reconfigure Area Boards to coincide with the nine reorganized Areas and will file amended regulations to do so. However, the Department is also committed to maintaining local Boards and CMHC Advisory Boards, in some capacity. Hospital boards of trustees will remain unchanged.

Planning for the Future: Increasing Service Demands

The last issue which the Department must be prepared to face in the coming months is related to the future of the Massachusetts economy. There is an increased need for services among homeless persons with serious mental illness. If the downturn in the economy continues, the Department must expect the demand for mental health services to increase. As the economy worsens, many people will lose jobs and housing, and many others will feel the stress of that threat. In addition, there are considerable stresses on families and children who had or continue to have a family member serving in the armed forces in the Persian Gulf. Many of these individuals may need the Department's emergency and outpatient services. Reductions already taken in these services threaten their ability to meet existing demand.

CHAPTER EIGHT

FUTURE AGENDA ITEMS

The following is a brief discussion of the Department's priorities for the next few years. Some of the agenda items can be managed without outside intervention or additional resources. Other initiatives require cooperation from other state agencies, and in some cases, support from the Administration and the Legislature.

Inpatient System: Hospital Consolidation

The Department of Mental Health currently operates seven state hospitals, the Gaebler Children's Center and one specialty treatment unit at a cost of \$167 million. The seven state hospitals are geographically diverse and vary considerably in terms of size and per patient costs. The highest per patient cost is \$288 per day at Northampton State Hospital while the lowest is \$195 per day at Metropolitan State Hospital. The median cost is \$244 per day represented by Worcester State Hospital.

In general, because of the significant amount of fixed costs in hospitals, the larger the hospital the lower the per patient costs. These economies of scale have led many to argue that the number of state hospitals should be reduced and consolidated. Advocates who support this view cite the census trends in state hospitals. Five years ago the hospital population was 2,196. Currently, the hospital population is 1,735 (421 patients are in inpatient community mental health centers).^{*} That is a decrease of 21% over five years.

Governor William Weld has appointed a 17 member Special Commission on Facility Consolidation (see page 17) to report to him in May, 1991. They will consider the following issues:

- What are the alternatives for currently hospitalized clients?
- What is the optimal size of a hospital, from both a cost perspective and patient care perspective?
- Will the reductions in census experienced over the past ten years continue or will the need for psychiatric hospital beds increase?
- How can revenue be maximized through hospital consolidation?

^{*} inpatient and community mental health center census as of March 23, 1991

- What is the maximum distance patients and families should travel in order to receive inpatient psychiatric services?
- What effect will hospital consolidation have on capital outlay requirements?

The Commission is considering these questions, and the Department will work with advocates and the administration on this issue.

Capital Outlay

Closely related to the issue of hospital consolidation is the issue of capital outlay requirements for the hospitals. Under Chapter 167 of the Acts of 1987, \$207 million dollars was appropriated for the renovation and upgrading of the seven state hospitals and the Gaebler Children's Center. Since that time, considerable progress has been made in the study and masterplan phases of the projects. Many of the projects are on the verge of final design, a key step prior to initiating construction. However, all projects are on hold pending the recommendations of the Governor's Special Commission (see above).

Utilization of Tewksbury Public Health Hospital

A proposal to create a fully accredited 80-90 bed mental health unit at Tewksbury Hospital serving Danvers State Hospital patients should continue to be explored. Transferring patients from Danvers would decrease the number of patients at our most overcrowded facility and enable the Commonwealth to capture reimbursement at the fully accredited Tewksbury Hospital. This proposal is being evaluated by the Governor's Special Commission.

Mental Health - Public Health - Facility Cooperation

Similar to the Tewksbury proposal, DMH currently operates an inpatient unit for Boston Area mentally ill clients at the Shattuck Public Health Hospital. Another proposal to transfer 14 medically ill/mentally ill patients to Rutland Hospital is in progress. The general concept of inter-departmental facility utilization is an area that will be further explored by the Governor's Special Commission. Benefits would include lower inpatient costs and improved patient care.

Community Service System

Current Housing Pipeline - Revenue Retention

The Department currently has 400 clients in state hospitals awaiting discharge to appropriate supervised residential programs. In addition, there are approximately several thousand mentally ill persons who are homeless or inadequately housed. These people have a right to decent housing in the community.

Current DMH plans call for the development of 1,000 additional residential beds over the next five years. Some of these beds can be supported by redeploying inpatient resources to support community living. Additional funding will be needed to support the housing agenda. The Department seeks approval to retain all revenues generated from case management services and rehabilitation services to implement DMH's housing agenda. This would quickly prove to be cost effective, as it will enable the Department to stay on track with hospital census reduction efforts.

Housing Models

It is important to consider the current (housing) settings available to the service system and the impact of those settings on clinical care. There are three issues in particular:

1. Use of multi-occupancy bedrooms: 31% of DMH's housing stock utilizes more than one resident per bedroom. This reliance on multi-occupancy creates problems in roommate matching and turnover and can limit the functional and clinical value of the housing stock. When a comparison is made between subsidized vs. unsubsidized housing stock, the function of multi-occupancy bedrooms becomes clear. Less than 18% of the subsidized bedrooms have more than one resident, while more than 63% of the unsubsidized bedrooms have more than one occupant. DMH needs to ensure that the use of multi-occupancy bedrooms does not increase during these difficult financial times which would be counter to the movement to create a greater sense of dignity and personal power for consumers of mental health services.

2. Integration of housing: Nearly 65% of the settings for DMH residential services are located in buildings where only mental health consumers live. The **supported housing** model would create the opportunity for more integrated living arrangements. In this approach, consumers move into independent apartments with an appropriate level of support. Over time,

the services decrease or increase as the consumers' needs change but the resident maintains the apartment as permanent housing. In this regard, DMH wants to build on the "set-aside" strategy that it has established effectively with the Massachusetts Housing Finance Agency. This strategy allows for the setting aside of a certain number of affordable apartments that are permanently established for the use of mental health consumers. The Department maintains control over placement into the units it controls, and the residents live there for as long as they choose. This gets DMH out of the development business and into service provision, consonant with its mission.

3. A balanced system: Of the Department's housing programs, 2% are specialized programs, 7% are high intensity residences, 24% are moderate intensity residences, 30% are low intensity residences, and 30% are flexible support (supported housing or satellite residential) programs. More work must be done to develop an understanding of a balanced service system. The needs of the service system must be measured in flexible terms, so that as the needs of consumers change, the balance of the system changes to match those needs. The issue of how the Department and/or its consumers gain access to affordable housing can determine the success or failure of providing such flexibility.

Psychiatric Rehabilitation Model

As discussed previously, the Department's efforts in maintaining a comprehensive community system, based on the rehabilitation model, is essential to our census reduction efforts. Any further cuts to the Department's community service system will hinder these efforts.

Home-Based Intervention

This highly intensive and time-limited service seeks to maintain children in their homes, or to return them to their homes as quickly as possible. This tested program model accomplishes this objective and is cost effective when combined with other services. A capacity to treat an additional 254 children and adolescents through this model is needed. Increasing the retained revenue cap for the 5047-0100 account would enable this to occur.

Enhance and Systematize Interagency Collaboration and Case Planning.

The Administration must direct state agencies which serve children, including the Department of Education, to develop strategies for reducing out-of-home placement and to develop a coordinated approach to service delivery and program planning.

Consumer Empowerment

The Department will continue its efforts to assist in the development of consumer leadership in Massachusetts, and to support the consumer and former patient efforts to address the stigma of mental illness. The Department will also increase the amount and significance of consumer preference in the development and provision of mental health services.

The Parent/Professional Advocacy League and Alliance for the Mentally Ill family support groups will continue to advise the Department on behalf of children with serious mental illness or severe emotional disturbance, and to promote the idea that parents can work as partners in the treatment of their children.

Forensic Mental Health

With increasing national attention on the interaction of justice and mental health systems, and increasing numbers of adults and children with serious mental health and emotional problems coming to court attention, DMH must determine the kinds of court-based triage, forensic evaluation, and case management services that should be provided by the Division of Forensic Mental Health.

As increasing numbers of persons with serious mental health and emotional problems are being incarcerated in correctional facilities (especially county facilities), DMH must determine the kinds of mental health services that should be provided by the Division of Forensic Mental Health in these facilities.

Administration and Management

Asset Management Board

The Commonwealth has a substantial amount of unused or under-utilized assets such as land and buildings on institutional campuses across the state. These assets could be used for the benefit of our clients and for revenue generation from leases or rentals to Government agencies and private organizations. The Legislature recognized this potential, and created the legal authority for an Asset Management Board with authority to approve temporary dispositions of assets for the good of the state.

The benefits to DMH and the Commonwealth could be enormous. Potential projects could include the lease of land for private development of housing, nursing homes, and hospitals which could serve our clients without using public capital dollars. The operating costs of these projects could be substantially subsidized by Medicaid dollars. Alternatively, some assets could be leased on the open market at market value.

While there is enabling authority for the Asset Management Board, public members of the Board must be appointed by the Governor. Further, the Board must develop and promulgate rules and regulations to implement the provisions of the law prior to any such asset management project.

Expansion of Client Registry and Client Tracking Systems

The Client Registry System has proven to be an effective mechanism for identifying individuals receiving selected services from the Department, providing important demographic and planning data about those individuals, and serving as a critical tool in the collection of federal reimbursement. The next step for the Registry will be its expansion to include individuals receiving state-operated inpatient services. With the inclusion of this population, scheduled for FY'91, the Registry will include all of the Department's most intensive service users. Long-range plans call for the eventual registration of all persons using ongoing Department services.

The Client Tracking System will be implemented across the state over the course of the next several months. By the end of FY'91, the Tracking System will report on the programs and services utilized by all clients receiving case management services from the Department. Long-range expansion plans for this system call for its transfer from a PC system to the state's OMIS computer system, and for the inclusion of non-case-managed clients (see pages 46-48 for discussion of management information system).

Managed Care Reimbursement System

The Department is currently in the process of issuing a Request for Proposals for a managed care project for FY'92. The goal of the project is to fund services which will enable the discharge of more than 100 long-stay patients from Department inpatient facilities.

Private mental health providers will be paid an annual rate to provide all necessary mental health, rehabilitative and housing costs for an identified group of clients. The providers will assume all financial risks related to the care of each client; if costs exceed the capitated rate, providers will face an operating loss, whereas innovative and cost-efficient programs and services will result in financial benefit to the provider. It is expected that such a model will result in improved client care in innovative, community-based, cost-efficient programs.

The project proposed for FY'92 is a pilot project. Requests for funding of a larger project will be submitted to the Robert Wood Johnson Foundation and possibly NIMH in the coming months and will include input from staff, consumers, family members and providers.

Management of Mental Health Benefits Under Medicaid

DMH is working with the Department of Public Welfare to assume management of mental health benefits under the Medicaid Program. This important initiative will ensure improved cost controls, as well as better integration of Medicaid and DMH policies regarding priority clientele and services. Savings generated from cost controls can be used to increase benefits or offset other mental health costs.

The first phase of implementing this project has been expansion of the Department's role in managing the Medicaid "Psych Under 21" Program. The "Psych Under 21" Medicaid option reimburses psychiatric hospitals for inpatient treatment provided to Medicaid clients under the age of 21. DMH has extended its responsibility for pre-screening all children and adolescents admitted to inpatient psychiatric hospitals under this program to further include periodic re-screening and screening of "conversions" (youth who become eligible for Medicaid reimbursement under the "Psych Under 21" Program during the course of hospitalization). This initiative ensures that only youth who are medically in need of psychiatric hospitalization receive such intensive and costly care.

DMH will continue monitoring "Psych Under 21" costs and utilization and will analyze other mental health services reimbursed under the Medicaid Program as the year continues.

**Addendum
to the
Comprehensive
Mental Health Service Plan**

September, 1991

ADDENDUM

OVERVIEW:

In November, 1990 William F. Weld was elected Governor and introduced a new philosophy and a series of new policy initiatives. He appointed a new Secretary of Health and Human Services to preside over a reorganized Secretariat in which separate Undersecretaries of Health and of Human Services now administer the agencies within the Secretariat. DMH is now within the Undersecretariat of Health. The Governor appointed Eileen P. Elias as Commissioner of the Department of Mental Health in June, 1991 as one of his first appointments for commissioners of the state's human service agencies. In assuming this position, Commissioner Elias was faced with the challenge of responding to four inherited issues which confronted the Massachusetts mental health system:

A state budget crisis which resulted in substantial reductions in funding for DMH.

A policy which required that three out of seven DMH state hospitals close. This policy resulted from the Governor's endorsement of the recommendation of his Special Commission on Facility Consolidation which convened in February, 1991 and released their report in June.

A policy initiative to transfer acute inpatient care now provided in DMH state facilities to private and community hospitals. This policy also resulted from the recommendations of the Special Commission on Facility Consolidation and reflects the Governor's commitment to privatization.

A state Medicaid managed care initiative which will create six Regional Management Centers by January 1, 1992 through which all mental health and substance abuse benefits for Medicaid recipients will be obtained.

The new DMH administration chose to lead and manage this set of inherited realities by planning and implementing its own proactive managed care initiative based upon cost-effectiveness, accessibility and a quality-based service system. DMH's managed care initiative is driven by the recognition that a service-based redesign of the delivery system is the best means to preclude externally imposed and fiscally

dictated restructuring. DMH sees this as an opportunity to shift the system even more assertively toward an organized community-based system of care.

The following sections describe the ways in which the new DMH administration has moved forward on the specific issues it inherited in June 1991.

1. Budget Reductions:

DMH's current services budget spending level for Fiscal Year 1992 is \$468.3 million. The Governor's FY '92 Budget Proposal called for \$449.97 million in spending, or a \$33.13 million reduction. It reflected a comprehensive strategy to close at least three state hospitals, targeting a cost reduction of \$30.2 million to be accomplished through expansion of residential beds and privatizing 420 acute inpatient beds. This strategy was to be supported, in part, through a unique 'Community Initiative Reserve' Account of \$14.8 million. This enormous systems change was coupled with a net spending reduction of \$18.3 million. But the Governor's Budget represented a clear strategy to maintain support for the community service system that was being challenged to support the transfer of more than 1000 formerly institutionalized patients into more appropriate community settings.

The final FY'92 DMH budget passed by the legislature took significant additional reductions. The Hospital Account was further reduced by \$1.9 million and Community Accounts were reduced by \$10.3 million, effectively eliminating the means to accomplish the reduction of \$32.2 million from the inpatient system.

The new administration of DMH has proposed a Minimum Budget which emerged from an assessment of the extremely complex and interdependent scenarios of facility closure and patient transfers along with the development of community programs and acute replacement services. It calls for \$18.7 million in additional funding for FY'92: \$11.0 million to allow for unanticipated demands relating to facility closure and \$7.7 million to maintain the community services essential to the successful movement of hospital patients. The Minimum Budget fine tunes the timetable for the implementation of institutional initiatives as well as maintaining the community service system and represents the minimum investment necessary to achieve unprecedented improvements in the quality of care and opportunities for independence as well as long term cost effectiveness of the entire mental health system.

2. Consolidation of Inpatient Services:

The *Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities* recommended in June, 1991 that the Department close three of its seven adult hospitals - Metropolitan, Danvers and Northampton - by the end of FY'92, thereby reducing the number of beds from 2,004 to 1,000. This will result in 700 new residential placements with associated community support services as well as the transfer of 300 beds to general hospitals and 200 beds to nursing homes. This action also affects planning for both short and long-range capital expenditures at the remaining facilities. Although masterplan studies of all inpatient facilities were completed as a result of a 1987 legislative directive, capital planning at the remaining campuses will be modified to reflect Commission recommendations.

In October, 1991 the Special Commission will meet to decide upon recommendations regarding privatization of the state CMHCs. The Special Commission will also make a recommendation in October regarding the Gaebler Children's Center. The Center is a 42 bed state-operated hospital providing acute and long-term treatment for children under age 14. It is the only state-operated inpatient facility available for younger children who need these specialized services because of behavior or the degree of pathology.

3. Acute Units in General Hospitals

The Administration's initiatives on state hospital closures and resulting consolidation and on privatization of acute inpatient services is bolstered by the agreement of the Administration and the Legislature to change the current hospital reimbursement system for psychiatric care in general hospitals. This agreement enables DMH to plan for the restructuring of its adult inpatient system. Existing hospital financing legislation (Chapter 23) expires September 30, 1991. Data resulting from a joint study undertaken by DMH and the Rate Setting Commission support advocacy for a new rate structure in successor legislation that recognizes the higher costs associated with psychiatric services, particularly for DMH priority clients who frequently require a higher staff to patient ratio and a longer length of stay. Alternatively, DMH expects to have the psychiatric inpatient hospital rate established outside of Chapter 23, to be negotiated with individual hospitals as a cost-based reimbursement system with an all inclusive per diem and rate differentials (higher at beginning of stay) which reward hospitals that can reduce the length of stay.

Intermediate, long-term, rehabilitative and some specialty care will continue to be provided in state-operated hospitals. However, DMH is developing community alternatives for acute admissions, enabling care to

be given in the patient's own community near family and friends with the dual benefit of normalized care for DMH consumers and maximized cost-sharing with the federal government. Although the transfer of acute inpatient care to general hospitals is the most substantive change, plans are being made to expand and coordinate community-based stabilization/emergency services in order to divert clients from inpatient care where appropriate, to alternative settings.

A DRAFT Request for Proposals for Acute Psychiatric Services in DMH Priority Units has been circulated for comment within DMH and to a broad range of constituency groups. The revised RFP is slated for release on September 30, 1991. These DMH Priority Units will be either replacement units for state hospitals with guaranteed access for DMH consumers or affiliation units wherein a certain number or percentage of beds are available for DMH clients. The combination of replacement and affiliation beds will support the expected downsizing of acute inpatient beds over the next three years due to the managed care initiative.

With the exception of the 42-bed Gaebler Children's Center, the inpatient needs of children and adolescents are currently being met in general and private hospitals and privately operated, contracted units in DMH facilities. Options for decentralized services to replace Gaebler are being evaluated, in accordance with the directives of the Governor's Special Commission, and may include two or three inpatient services at sites which include private psychiatric hospitals and specialized units in DMH hospitals. Should the Commission recommend that Gaebler remain open, or should the decision be deferred, Gaebler is ready to apply for HCFA certification which will generate additional revenue and ensure the highest quality of care in that facility.

4. Integration and Management of Medicaid Benefits:

The DMH managed care initiative has provided direction for the planning process with the state's Medicaid Office specific to Medicaid's managed care plan for Medicaid funded mental health and substance abuse services. Medicaid has applied for a waiver from the federal government which will allow implementation of a managed care system for all Medicaid recipients (except those exempted by federal law) for all Medicaid State Plan services.

It is anticipated that all of these funded mental health and substance abuse services will be obtained through one of Medicaid's six Regional Management Centers (RMCs) intended to be operational by January 1, 1992. DMH has actively negotiated a positive understanding with Medicaid to develop a process which directs each RMC to negotiate with DMH. This

will enable the CCSS planning and implementation to proceed so that DMH priority clients, who are Medicaid recipients, continue to be served appropriately by existing DMH providers. This system supports the integration of the DMH managed care initiative with the Medicaid managed care system.

This Addendum builds on the vision of a comprehensive community-based mental health system in the May, 1991 Comprehensive Mental Health Service Plan. The values and goals remain the same, the methods and timetables are revised. The Revised Plan includes and articulates the concepts necessary to operationalize the vision.

The Foundation of this new era in the planning, development and delivery of mental health services is DMH's commitment to **MANAGED CARE, ACCOUNTABILITY** and **PARTNERSHIP**. These principles will drive the restructuring of the system.

PRINCIPLE #1: MANAGED CARE

MANAGED CARE is the first of the three principles directing reform and restructuring of the Massachusetts mental health system. MANAGED CARE, as the term is defined by the Massachusetts DMH, is a service delivery system within DMH consisting of the Comprehensive Community Support System as a service model with the Local Mental Health Authority as the fiscally accountable entity. Its intent is to ensure a coordinated and integrated service system that is cost-effective and quality-based with emphasis on helping persons remain in the community and that ensures access to all needed mental health services.

COMPREHENSIVE COMMUNITY SUPPORT SYSTEMS:

Each of DMH's nine Areas will identify and develop Comprehensive Community Support Systems (CCSSs) which are a client-centered mix of state and vendor-operated services located in a natural service area with a common geographic, political and demographic profile. There is no predetermined number of CCSSs statewide but, based upon existing natural service areas, it is presumed to be about 25. The CCSSs will maintain the seriously mentally ill or severely emotionally disturbed individual in the community at his/her highest level of functioning, will

ensure linkage between the client and needed services and will include the following components:

- * *Acute Care Mental Health Services* - community-based stabilization/emergency services and inpatient treatment;
- * *Supportive Mental Health Services* - ongoing treatment and rehabilitation support inclusive of community-based services (outpatient, psycho-social/clubhouse day programs, day treatment and day activity programs, home-based treatment, therapeutic recreation, residential, etc.) and long-term hospitalizations - the basic components of managed care in the DMH system;
- * *Advocacy Mental Health Services* - case management, legal assistance, family support groups, consumer empowerment activities;
- * *Generic Community-based Services* - the full range of non-mental health services on which citizens rely;
- * *Informal/Significant Other Supports* - the ongoing support provided by other consumers, family members, clergy, landlords, friends, etc.

The specific CCSS service configuration and methods for integrating and coordinating them will be recommended to the Commissioner by the Area Directors. Recommendations will be the product of the Area Work Groups on Managed Care whose members will include the range of mental health constituent groups. Each CCSS recommendation must be approved by the Commissioner in order for the Area to proceed to the next implementation step of MANAGED CARE, establishing Local Mental Health Authorities.

Key to developing successful CCSSs is the expansion/reorganization of the acute care services and their integration with supportive mental health services. In addition, case management must be reorganized. The following summary of case management describes where the Department is now and the direction in which it plans to evolve this critical link in the restructuring of the DMH system.

CASE MANAGEMENT:

Current DMH case management policy, based on a "brokering model," was developed in 1987 to assist adults with serious mental illness and

children and adolescents with serious mental illness or severe emotional disturbance in:

- determining, gaining access to and linking needed services and entitlements;
- developing and amending individual service plans and
- monitoring the responsiveness, quality and effectiveness of provided services.

Currently, DMH case managers serve 7,372 adults and 787 children and adolescents. There are 672 adults and 77 children on an active case management waiting list. Priority for case management services is based on specific categories of need that include but are not limited to:

- adults waiting for discharge from DMH inpatient units
- homeless persons with serious, long-term mental illness
- children receiving inpatient hospitalization, referred for hospitalization, at risk of hospitalization or receiving residential or day treatment services

The Governor's Special Commission Report on Facilities Consolidation of June, 1991 recommends expansion of (federally reimbursable) case management services as a critical component of the community service system to ensure coordinated continuity of care. This recommendation presumes implementation of the DMH managed care initiative wherein case management is a key service.

DMH has substantially and successfully expanded its case management capability since 1987 (see September, 1990 P.L. 99-660 Status Report) but the time has come to evaluate the Department's policy and practice. The DMH managed care initiative, which will create a greater demand for case management, makes this a primary focus area. It is not only important to maximize the use of existing resources but also to expand the case management system in a way that optimally meets the needs of the Department's priority clients. As a part of this examination process the current model will be reviewed.

In addition to the "brokering" model, the other models of case management services currently provided to DMH clients by primary clinicians, residential counselors, outreach workers, etc. (but not recorded or documented by DMH as case management) will be reviewed as part of system restructuring. Due to its brokerage model case management policy, the Department is not able to capture all of the case management services it provides either directly or through its various vendor agencies.

A revised DMH policy regarding case management will be formulated this year to ensure that resources are used in the most efficient way and that DMH priority clients have access to the most appropriate and available services. A shift in the case management model from emphasis on brokering to emphasis on outreach oriented, clinical case management is contemplated and will be planned as restructuring continues.

Local Mental Health Authorities:

The Comprehensive Community Support System is the basis for the Local Mental Health Authority (LMHA) and the first step in its development. The LMHA becomes the fiscal entity supporting the service system. The Department intends to pilot three to five LMHAs in the next year and then eventually implement a state-wide system of local mental health authorities. A LMHA may be a non-profit or public agency which is authorized to receive governmental (DMH, Medicaid, Medicare, etc.) funds on a performance contract basis. It may sub-contract with a network of private vendor and state-operated service providers to furnish all required care to a DMH consumer. It is anticipated that the authority of the LMHA will encompass all aspects of care including hospital admissions and discharges, access to residential and other community support services and coordination with the DMH area system. The LMHA will also be responsible for developing local systems for coordinated service planning with the Department of Social Services, local school systems, and juvenile justice agencies.

PRINCIPLE #2: ACCOUNTABILITY

ACCOUNTABILITY is the second of three principles directing reform and restructuring of the Massachusetts mental health system. It refers to the commitment of DMH to be responsible and to be held responsible for planning, management and oversight of a high quality mental health system.

CLIENT ASSESSMENTS:

A Level of Care Assessment instrument, based on the New York and New Jersey models, has been completed and will be administered on a routine basis beginning in October in all DMH inpatient facilities, not just those facilities slated for closure. The assessment will classify degrees and types of services that DMH clients need in order to maintain their highest quality of expected adjustment in the least restrictive environment. Elements of level of care classification include: expected and highest level of physical and social functioning; physical and social environmental resources, including the family's potential for involvement and

participation; level of skills in self-care and control of emotions; degree of services that agencies should provide for the client; and types of environments in which a client can be expected to maintain an optimum level of adjustment.

In addition, through the advocacy of consumers concerned with the subjective assessment of client preferences, a pilot project has been approved in which consumers will interview patients in each of the three hospitals planned for closure. Patients will be asked about their perception of their abilities and needs and about their concerns related to moving from their current hospital setting.

DMH SCREENING TEAMS AS GATEKEEPERS:

All referrals to the Acute DMH Priority Units will be made through the DMH screening teams who are the gatekeepers of the current area service systems for emergency care and inpatient admissions. With the development of the Comprehensive Community Support Systems, the screening teams will be the primary monitors for managers at the local level. They will become an integral component of system utilization review processes.

OVERSIGHT OF GENERAL HOSPITAL & PRIVATE PSYCHIATRIC INPATIENT ACUTE PRIORITY UNITS:

Evaluation of quality of care standards, of utilization rates, citizen monitoring programs and human rights committees will be established for these units. The RFP for Acute Psychiatric Services includes stipulations for human rights and citizen monitoring.

QUALITY ASSURANCE:

DMH is revising its Table of Organization to emphasize the significance of Quality Assurance and will name a Director of Quality Assurance who will report to the Commissioner to oversee the continuance and/or establishment and implementation of quality assurance standards throughout the system for adults, children and elders. The primary function of the Director of Quality Assurance will be to ensure the integration of inpatient and community services into one Comprehensive Community Support System.

PERFORMANCE-BASED CONTRACTING:

Purchased services will be measured quantitatively and qualitatively and will structure the payment and contract renewal mechanisms for all contracts. Performance will be gauged against stipulated outcome measures.

PRINCIPLE #3: PARTNERSHIP

PARTNERSHIP is the third principle directing reform and restructuring of the Massachusetts mental health system. Partnership is the process by which the policies directed by the Commissioner to restructure the mental health system will be operationalized and monitored at the state and Area levels. All constituent groups (including consumers, families, unions, vendors, professionals, legislators, and representatives of the business and academic communities) have been invited to work with the Commissioner and staff at the state level and with each Area Director and his or her staff at the Area level. DMH's goals for PARTNERSHIP are to share information about policies, to listen to input from the constituent groups including the identification of pertinent issues, to seek consensus on operationalizing the policies, to work with the constituent groups to determine monitoring standards and procedures and to participate in the monitoring process.

AREA REORGANIZATION:

During August, 1991, the Commissioner convened meetings in all of the nine DMH Areas to plan for the implementation of a Comprehensive Community Support System (CCSS) in each Area. Each meeting was designed to begin a participatory planning process involving Area staff, Area Board members, hospital trustees, consumers, advocates, family members, elected and appointed officials, providers, state employees and other interested parties. Each Area was asked to develop, collaboratively, a process for the development of a CCSS plan. Plans will be in place by the end of FY'92.

Information generated at the meetings enabled each Area Director to begin CCSS planning as well as a timetable for FY'92 budget re-allocations and FY'93 budget planning. The intent is to parallel the P.L. 99-660 planning process to develop Area plans that tie together into a state plan that meets federal requirements while ensuring maximum participation of all interested parties.

STATEWIDE AND AREA WORK GROUPS:

The August Area meetings were followed by a statewide Forum, "Restructuring the Massachusetts Mental Health System, A Participatory Process of Change," on September 5th at the State House and attended by more than 550 people. The DMH initiatives were presented followed by question and answer periods on Facility Consolidation and Managed Care. The Forum provided information regarding the formation of Work Groups on

Facility Consolidation and on Managed Care at the state and Area levels and extended an invitation to participate. Over 300 persons have volunteered to date.

The first meetings of the statewide Work Groups are scheduled for the end of September. Sub-groups on major issues within the Facility Consolidation and Managed Care initiatives will be created. Both the state and Area Work Groups will assess the current system; define the parameters and standards of a restructured system; and identify the gaps which must be filled. Because the statewide Work Groups will address statewide issues and set standards, the Area Work Groups, which are more focused on operationalizing the policies and standards, will formally convene near the end of the calendar year though most Area Work Groups are using this period of time to evaluate the Area service systems in order to determine the configuration and number of CCSSs.

Technical assistance by DMH staff is being extended to the statewide Work Groups and to the Areas. DMH central office will approve each Area plan.

OUTREACH TO CULTURAL & LINGUISTIC MINORITIES:

The participation of constituents representing cultural and linguistic minority groups is crucial to the success of the participatory process. Recruitment of minorities to volunteer for the state and Area Work Groups is in progress. In the third week of September, DMH is mailing all minority constituents (including consumers, families, vendors, legislators and DMH minority employees) a full packet of the handouts of the Forum of September 5 explaining the DMH restructuring and the participatory process. Included is the announcement of a statewide minority constituents' meeting in late October to be chaired by the Commissioner and the President of the State Advisory Council. Interpreters for each major linguistic minority will be available. That meeting is intended to offer an opportunity for expanded input on specific system and service issues of importance to the minority community. Recommendations compiled at that meeting will be incorporated by the statewide Work Groups.

INVITATIONS TO NEW AND EXPANDED PARTNERSHIP:

The Work Group is the core of PARTNERSHIP during this season of change in the Department. But it is not the only activity reflective of the commitment to PARTNERSHIP. DMH is creating an Academic Advisory Board and a Business Advisory Board in order to tap the expertise of diverse professionals and engage their interest and assistance in meeting our goals for restructuring.

DMH is in the process of formalizing the Ad Hoc Consumer Group by establishing a Consumer and Ex-patient Advisory Council. Subcommittees of the Group have met to draft recommendations regarding the formalizing of a Council and the establishment of an Office of Consumer Relations. These recommendations will be reviewed on September 24 at a statewide consumer meeting and forwarded to the Commissioner for approval and implementation.

INTERAGENCY CHILDREN'S INITIATIVE:

The Commissioner of DMH has made a commitment to the development of a strong interagency service network for children. A meeting has been scheduled for November, 1991 with the commissioners of the other state child-serving agencies to secure their commitment to this goal and identify necessary steps for implementation. The Metro-Boston Area has been charged by the legislature to prepare a report by April, 1992 assessing the feasibility of implementing the Ventura, California model of interagency service delivery. The assessment of the Ventura project and the CASSP local interagency demonstration project in Lynn, Massachusetts will shape the interagency network on a statewide basis.

